

Conversations with Medical Informatics Pioneers:
An Oral History Collection

Fostering Health Policy and the Biomedical Informatics Profession

2006 Interview of Don Detmer

Interviewers:

Joan S. Ash & Dean F. Sittig

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U.S. National Library of Medicine

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Published by the U.S. National Library of Medicine, June 25, 2015; updated September 4, 2015.

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Suggested citation:

Detmer, DE. "Fostering health policy and the biomedical informatics profession," Conversations with Medical Informatics Pioneers: An oral history collection. Ash JS, Sittig DF, interviewers. Goodwin RM, Ash JS, Sittig DF, editors. Bethesda: U.S. National Library of Medicine (NLM); 2015.

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Oral History Interview with Don Detmer

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2006 Interview of Don Detmer

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Source: Personal collection of Don E. Detmer.

Dr. Don Detmer, 1984, when he served as Vice-President for Health Sciences, University of Utah.

Fostering health policy and the biomedical informatics profession

Don Eugene Detmer, MD, served a pivotal role in crafting the US National Health Information Infrastructure. He chaired a 1991 Institute of Medicine (IOM) committee charged with improving the patient record, which generated a landmark report called “The Computer-based Patient Record.”

INTERVIEWED BY
JOAN ASH AND DEAN SITTING

JANUARY 21, 2006
PHOENIX, ARIZONA

Dr. Detmer is University Professor of Health Policy Emeritus and Professor of Medical Education at the University of Virginia and Visiting Professor at the University College London’s Centre for Health Informatics & Multiprofessional Education (CHIME). He served as President and CEO of the American Medical Informatics Association (AMIA) from 2004 until 2009, when he became Senior Advisor to AMIA until 2011.¹

He chaired the Board on Health Care Services of the Institute of Medicine (IOM), the National Committee on Vital and Health Statistics (NCVHS), and the Board of Regents of the National Library of Medicine. He was a Commissioner on the HHS Commission on Systemic Interoperability, which published the report “Ending the Document Game: Connecting and Transforming Your Healthcare through Information Technology.”^{2,3}

In 2013, he stepped down from his position as the inaugural Medical Director for Advocacy and Health Policy of the American College of Surgeons. Dr.

Detmer has also been a consultant to the government of England and Wales and the Hospital Authority of Hong Kong. From 1999 to 2003, he was the Dennis Gillings Professor of Health Management at Cambridge University and is a lifetime member of Clare Hall College, Cambridge. He was Vice-President for Health Sciences at the Universities of Utah and Virginia, where he led implementation of a physician order entry system and was Principal Investigator of its IAIMS grant. While at the University of Wisconsin–Madison, he co-developed the nation’s first Administrative Medicine Program, a master’s degree program for clinician executives.

As a surgeon, he was instrumental in the adoption and development of ambulatory surgery in the early 1970s and was the team physician for the Wisconsin Badgers for 10 years while also serving as President of the Medical Staff. He earned his MD from the University of Kansas, and had subsequent training at the National Institutes of Health, the Johns Hopkins Hospital, Duke University Medical Center, the Institute of Medicine, and Harvard Business School. His MA is from the University of Cambridge.

Dr. Detmer enjoys spending time with his grandchildren, riding horses, fly-fishing, reading biographies, and various crafts.

The only person who could get up in church and leave during the middle of the service—with everyone acting like it was **terrific—was Dr. Howarda. He was clearly doing good work. That’s** how I decided I wanted to go into **medicine.**

JA It’s January 21, 2006, and Joan Ash and Dean Sittig are interviewing Dr. Don Detmer. We’re at the college meeting [ACMI] in Arizona, and as I warned you, my first question to you will be, give us 5 to 10 minutes of background on where you were born and raised—especially what you think led you to your interest in informatics.

DD I was born in Winfield, Kansas, which is a small town that now actually has a pretty famous bluegrass festival annually. At the time I was born, the last of my parents’ three children, it had a small college, St. Johns. All five of my grandfather’s children—all girls—got college degrees there in the 1920s, and my mother met my father there. He was from Winfield. When I was 3,

we moved to Lindsborg, Kansas, which, as I joke, is so small it says, “Welcome” and “Come Again” on the same sign. It wasn’t quite that small, but it was pretty small. They have a little Swedish-Lutheran college



Source: Personal collection of Don E. Detmer.

Don, one year old, on Grandmother Martha McCormick’s lap at the family reunion in Newkirk, Oklahoma, 1939.



Source: Personal collection of Don E. Detmer.

Don, two years old, circa 1940.

there, Bethany College, and at one time, the king of Sweden took the effort to visit it. I was a minority group, because our family were German-Lutheran, and everybody else was Swedish-Lutheran. So I actually experienced in that day and time what it was like to be a minority. It was both broad and narrow-minded in the way monocultures can be.

It was a very artistic community. Everyone played two instruments and sang, and the only debate was which two instruments. So you got a lot of culture despite it being a little community. All the adults felt totally free to correct you when they saw you doing something that they didn't think was right, and, conversely, to praise you when they thought you had a skill that was commendable. My mother saw that I had six years of perfect attendance to Sunday school, which instilled in me that showing up and being on time counted for something in life. The only person who could get up in church and leave during the middle of the service—with everyone acting like it was terrific—was Dr. Howarda, the GP [general practitioner] in town. He was clearly doing good work. That's how I decided I wanted to go into medicine. [laughter]

DS *That's the best one yet.*

DD That's actually a truthful story, because I was the first person in any of my family, in any direction that anyone could ever recall, that became a physician. So

anyway, that really didn't lead so much to informatics, but it did lead to a career as a health professional.

On the other hand, something that I do think led to informatics was a subsequent move to Great Bend when I was in junior high school. Great Bend was at the edge of ranching country, while Lindsborg had more a farming culture. Great Bend was in the oil and cowboy culture. And so I reflect an admixture of

both the farmer and cowboy mentalities—and they're definitely not the same mindset. Occasionally, I'm very interested in flying off and being pretty nonlinear. But on the other hand, I'm also quite willing to water things and see them grow. And in Kansas, tornado country, God wipes things out, and certain unplanned things happen, and

you never understand why. So there is this admixture in my personality that is well suited to a new discipline like informatics. Also, I was in two tornadoes as a kid, so every day seems like one that has been given to me.

When I was a sophomore in high school, Kansas University—which seemed at that point the edge of the universe as far as anything intellectual—had a science and math camp. So I started working in science labs—even before I graduated from high school—with grad students. Ultimately, I got a job coming back there every summer. And so I was doing some element of biomedical research from the time I was in high school, despite being from the middle of nowhere,

I started working in science labs—even before I graduated from high school—with grad students.



Source: Personal collection of Don E. Detmer.

Don with his brother, Mac, and sister, D.J., on Mac's pony, circa 1940.



Source: Personal collection of Don E. Detmer.

Don harvesting grandmother Martha McCormick's garden with his sister and cousin, circa 1942.

including presenting a paper my freshman year in med school, at a national Society for Cell Biology Meeting, with four Nobel laureates in the audience. It was the most distinguished small audience I've ever actually addressed as a result of a competitive paper. It was all downhill after that. But at any rate, I guess I did get a context for an academic life early, and the crucial importance of the right question and having good data. Actually, it was kind of iconoclastic and somewhat negative as well as positive for me, because by working and growing up with graduate students, I developed a very chippy, impulsive kind of mind, rather than just falling in and going with the flow and sort of thinking everything sounded pretty reasonable, so just go with it. I challenged an awful lot of things in my own mind. And since I wasn't really all that bright, it made it somewhat iffy about whether, in fact, I would achieve some of my career goals, because I'd go off on my own interests at too early an age. But at any rate, those are just some quick reflections.

JA Has that been a problem for you?

DD Yes, it has. For example, I never passed my oral boards in surgery, because they wanted me to answer some questions I didn't think, frankly, were in the interest of good patient care. They subsequently changed the boards. But I got elected to the American College of Surgeons without board certification, and I ended up becoming a member of the American Surgical Association, which, as Dr. David Sabiston, who was my chief of surgery said, quoting Bob Zollinger, "That's when you can call up your old chief and tell him to go to hell." There's an example of where I didn't follow the usual path. While it didn't necessarily hurt me, on the other hand, obviously, it caused me some angst over the years, as well as, unfortunately, angst to some of my mentors, who were always extremely supportive.

JA Can I go back? That first physician, Dr. Howarda, who was able to get up and leave church, did he in other ways have an influence on your life?

DD Yes. I was also a more than rambunctious Boy Scout. I got 21 merit badges at one Court of Honor at one point and ended up as an Eagle with two palms and one [badge] short of three. A few years earlier,



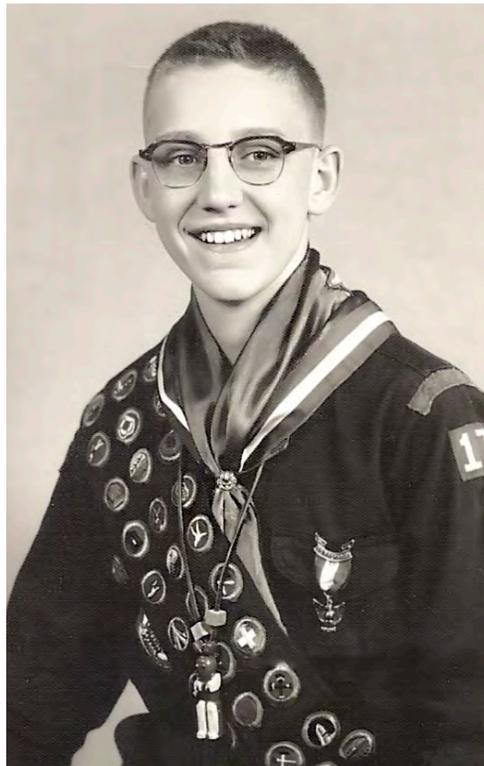
Source: Personal collection of Don E. Detmer.

Don, his mother Esther, grandfather Austin McCormick, brother Lawrence (Mac), grandmother Martha McCormick, father Lawrence, and sister D.J., celebrating his grandparents' Golden (50th) Anniversary.

I had to personally seek out Dr. Howarda to supervise my Safety and First Aid merit badges, because there was not a sufficiently developed scouting movement in Lindsborg. The hardware store owner agreed to become my Gardening merit badge sponsor and so it went. As a result, I received my Star badge before I left Lindsborg. So I got to know Dr. Howarda personally, and he was really very helpful. It was great of him to take the time to do that, and his doing that was a great life lesson as well. I also had had a very bad leg laceration from running alongside a barbed wire fence at dusk one night, and it really was bleeding quite a bit, and he was out on a call. But my folks reached him by phone, and he said, “Pour turpentine on it, because it’ll staunch the bleeding, and I’ll be there as soon as I can.” That also made a real impression. I figured anybody that my folks would follow through on that kind of advice—because it really hurt...

DS I can imagine.

DD I thought, “Boy, whatever he was doing has got to be a pretty potent thing.” Having said that, later, as I got to know him as a person, he was really a wonderful man. It was that mix of things that led me to medicine. Medicine was, without a doubt, the most exciting thing going on in my environment there. So it looked both challenging and worthwhile—those things appealed to me.



Don wins Eagle Scout Award, circa 1955.

Source: Personal collection of Don E. Detmer.



The newlyweds' first big trip. Mary Helen and Don Detmer in Central Park, NYC, 1961.

Source: Personal collection of Don E. Detmer.

JA We're up to college.

DD Yup. Spent a year in England in Durham. At times in my life, I spent time in Derm and Dur'am—both spelled the same way: Durham, North Carolina, and Durham, England. But mostly I was an undergrad at Kansas, met Mary Helen, my future wife, went off to England for my junior year, came back, re-met her, eventually eloped mostly to save the money, and I actually got into medical school 14 hours short of an undergraduate degree. That's another example of an atypical career. I didn't get credit for all my academic work in England, but the medical school at KU accepted me without a degree. And so I had worked eight years before receiving my first degree. Until adding a master's degree at Cambridge years later, my MD degree was my only academic degree. But, having said that, I ultimately graduated with membership in Alpha Omega Alpha my senior year, but it wasn't on the basis of my first two years of work since I never was a scholar who figured out how to do well on most course examinations. It was really on the basis of my clinical years, where I really just absolutely loved patient care, and really got fired up.

Catherine, our first daughter, was born at the Kansas University Medical Center. Then we went to Hopkins for my residency, and our daughter Emily was born there, and then to NIH with Dr. Andrew “Glenn” Morrow at the Heart Institute, surgical branch. I got interested in health policy

while there. In fact, at Duke as a resident, I worked to get North Carolina to pass inflammable fabric legislation for kids' pajamas, because at that time a lot of children were getting bad burns from open stoves. I had had such a patient as an intern in Baltimore. So as a resident, I tried to get some flame-retardant legislation through since North Carolina had a large textile industry. Throughout my career, I've had a commitment to preventive medicine, public health, and individual patient care—sort of denominator medicine as well numerator medicine, if you will. And I guess from that, I also got interested in both policy and issues relating to administration, and frankly, how badly we administered healthcare systems in those days at least in terms of pursuing systems thinking.

So when I was at Duke, rather than going on into cardiac surgery, which would be all consuming of my time and energy, I decided to pursue an emphasis in general and peripheral vascular surgery, and then get tooled up, trained up, to do administrative medicine, as a sort of minor emphasis area since it wasn't a defined field then—I'd help create that field, if you will. And so I pursued in my career policy

and medical administration as my basic sciences, in combination with clinical surgery. Ultimately, I combined health policy, particularly in relation to quality of care and tied it to my surgical practice, rather than doing a bench laboratory science as a “minor,” if you will, which was the norm for Sabiston-trained surgeons. Dr. Sabiston was very supportive of

this plan, and he sent me to see Dr. Larry Weed in Vermont with respect to computer-based medical records and Dr. Ivan Bennett at Columbia, then director of the New York Hospital, for advice on these areas for career tracks.

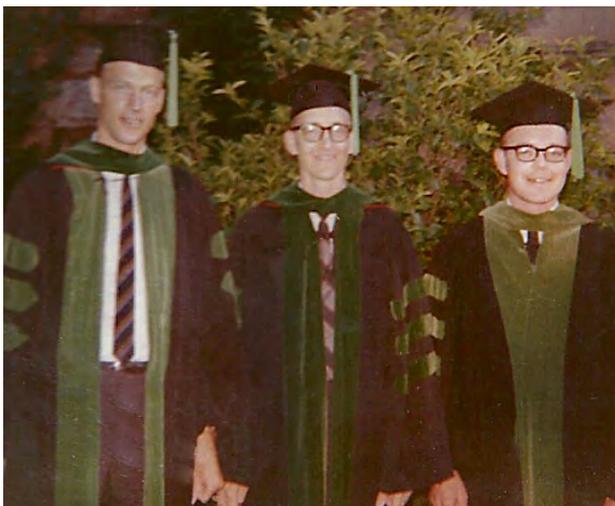
Also, while I was a resident I helped develop the modern era of ambulatory surgery coincidental to a couple of clinicians in Arizona

who were innovating free-standing surgicenters out there. It was an administrative innovation I undertook with Dr. James Davis at the community hospital in town. We got Blue Cross-Blue Shield involved in evaluating the project. After the study, Virginians learned that the North Carolinians were doing this, so of course, they had to do it, to be competitive. And pretty soon the entire South was doing it, and then it sort of spread across the country.



Don served as a research assistant in the laboratory of William Balfour, MD, and Fred Samson, PhD, in the KU Physiology Department, as featured in the *Kansas City Star* newspaper, July 1958.

Source: Personal collection of Don E. Detmer.



KU Medical School Graduation Day, 1965, Don Detmer (center) with best friends Merlin Olsen and Ken Gray.

Source: Personal collection of Don E. Detmer.



Detmer family at NIH, 1967.

Source: Personal collection of Don E. Detmer.

JA South was doing what?

DD Sorry, I'm ahead of myself. Reimbursing hospitals and surgeons for performing ambulatory surgery. It had been shown some years earlier, both in the UK as well as the US that you could perform ambulatory outpatient surgery, same-day surgery, on a lot of procedures. We showed you could do it both safely and more economically. Until then, no one had tested it as an administrative innovation with a formal evaluation. And it turns out, by dumb luck, we did something that was really very smart. Since the hospital didn't have the capacity to do the economic analysis, we enticed Alex McMahon, then head of Blue Cross-Blue Shield, to do that part of it. When it proved to be high quality and cost effective and preferred by patients since they were back home in their own bed at night, they began to pay for it. That had always been the trouble, getting reimbursement for doing surgery delivered that way.

Also, I mentioned medical records earlier. While a resident, I changed the surgical record at Duke. The surgical record there hadn't been changed since the hospital opened—you know, typhoid fever

and diphtheria were on the original questions that you would ask. And of course nobody had seen such diseases for 30 years. So I updated it and also developed a preoperative checklist protocol, to make care more orderly and efficient so you wouldn't have this constant situation of, "Well, did we get the white count on this patient?" You know, in the OR the day

of the procedure, or, "We'll have to cancel the case or at least wait until we get the chest X-ray." So I started a checklist the night before the procedure so that early the next morning, we were ready to go. Unfortunately, I was too busy clinically to publish that work.

Well, I finished my residency at Duke and headed for the Institute of Medicine to add expertise

relating to policy and administration.

JA Can I backtrack just a minute and ask you why you chose surgery?

DD I've always had good psychomotor skills, and I like surgery, I like to use my hands. I still do needlework and crafts, and even fly fishing is actually an interesting combination of mind and matter. But surgery, I have to admit, is really just piecework, but it's piecework with finesse. It's challenging to figure



Source: Personal collection of Don E. Detmer.

Christmas breakfast with daughters Emily and Catherine at home while Don was a medical resident at Johns Hopkins, January 1967.



Source: Personal collection of Don E. Detmer.

Don and Dr. Glenn Morrow, Chief of Heart Surgery Branch, NIH, where Don was a Clinical Associate from 1967 to 1969. Dr. Morrow also taught Don how to fish for bass.



Source: Personal collection of Don E. Detmer.

Performing tricuspid valve replacement in a calf in Building 3 at the NIH. Don performed 230 valve replacements in calves with his prosthetic valve work between 1967 and 1969.

out what's wrong and how to fix it. So I found also, in my surgical career, I drift toward those surgical areas that hadn't been explored that much.

It's oftentimes taking the extra time to listen carefully to the patient and really eliciting information and then tracking the data and finding out what was said that matters and what is just noise, what isn't in the literature, and over time being able to then make the right diagnosis, so you then would know whether to offer a surgical approach to the patient or not, but also what technique is best, and then to track the outcomes very carefully to improve performance over time. It is basically just informatics—the science of using information. I mean, when I applied, for example, for fellowship in the American College of Surgeons, I think I was the only person to also submit my patient outcomes at six weeks to two months, as well as just “yes, I've done these operations” on their checklist. You know, if you operate on a leaking or ruptured abdominal aortic aneurysm, but then all your aneurysms die, you didn't necessarily do much for those patients. I was interested in the career of E.A. Codman, who helped lead the American College of Surgeons to found the Joint Commission for American hospitals.

So I would say I like surgery—I liked it intellectually, but I also loved it technically. I'd say those are probably the main motivators. One of the downsides, of course, it's very time-intensive, very labor intensive. So after four years of high school, four years of college, and seven years of surgical training, by the time I, quote “hit the world,” I was a pretty old guy. So that was the downside of it. But the upside was I always enjoyed it, and if you did it well enough, you sought out more demanding challenges—and that's why I moved to vascular, because vascular surgery often—carotids or aortic replacements or other blood vessel bypasses—if you did it right, it usually always worked. If you didn't do it right, it was usually

a disaster. And so I liked that walking on the edge, and really handling cases of patients who might later think it all seemed rather simple.

And then also supporting the patient through it as a person while also working with their family. So, the best of all worlds is when the resident and I are transporting the patient down the hall to the recovery room one morning, for example, about nine in the morning, after we had done an emergency aortic aneurysm resection for ruptured abdominal aneurysm in an 86-year-old farmer who collapsed during his morning jog, and the student's comment on the way is, “I read about this last night before going to bed. It sounded like it was supposed to be really hard and most people die, but that looked real easy.” You know, that kind of thing. So it had a lot of challenge to it. But on the other hand, it could actually be done right. I mean, oncologic surgery is also hugely challenging. But

my personal disposition is that I prefer quicker wins.

And you didn't always win, obviously, in this kind of work, so it was at the same time very real. Sometimes you got patients with paper thin aortas that couldn't hold a stitch, or who were just essentially Humpty Dumpty with multiple systems in failure. But still, to care for a patient even when dying, with their death imminent, and relating to that person as well as his or her families, I found really also challenging, really personally challenging, yet also ultimately a very human kind of work. You suffered with them, but you tried to make it better than it otherwise might have been. And that, I think, was also something that kept me practicing. I mean, I practiced surgery until I went to the UK in 1998, and I would have practiced over there since they planned on my doing so. My first talk in the UK was actually on a sports medicine panel outside Nottingham. But the London bureaucracy was so slow to authorize my credentials to practice there that I realized after two and a half years of intermittent, unproductive dialogue with the General



Source: Personal collection of Don E. Detmer.

Mary Helen and Don at the Southern Surgical Association, 1971, when Don was a surgical resident at Duke presenting a discussion of his paper on a new Ambulatory Surgery Unit he developed with Dr. James Davis.

Medical Council in London that I'd been involuntarily retired after 25 years of patient care.

DS Waiting.

DD Yes.

JA I am also anxious to ask about Larry Weed. You had a fairly early association with him in your career. How did you get together, and how did it turn out?

DD Well, it's very interesting and was fascinating for me. I don't know if you saw it, but Charlie Safran and I just recently were quoted in an article about Dr. Weed in *The Economist* a few weeks ago.⁴ Early in my career, I actually went up to Vermont and the experience was typical of Larry Weed. He not only took me around his lab, but also had me to his home for dinner with his wife and family. It was inspiring.

JA How old were you?

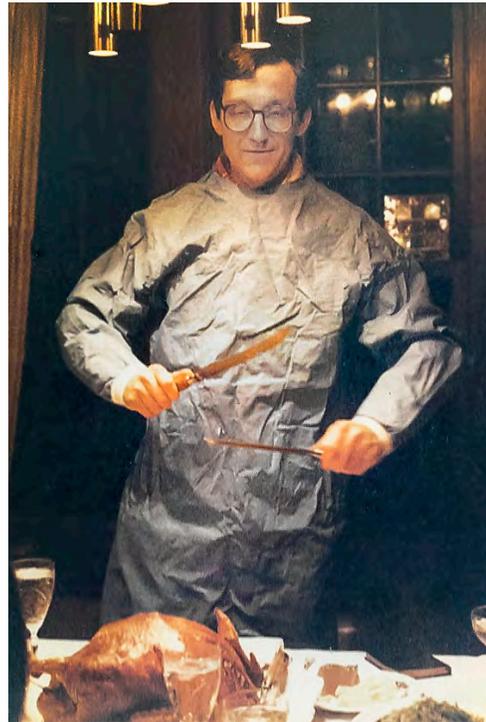
DD I was a resident at Duke, so I don't know, what, 30, 31, something like that. And a surgeon, right? Not an internist like him. But anyway, we have stayed in touch over the years—not a lot. When it came to the

membership for the IOM Computer-based Record Study, the '91 study, people were advocating that we put Larry on that committee. By then, I knew him well enough to call and be very direct about it. His

reaction was, "Well, Don, you don't need an IOM committee to do a report. I just told you all that is needed." And I knew that this was his definitive belief. So, we didn't put him on the committee, but we did put one of his very good colleagues on it, a person he recommended, and even that good fellow, before the study was over, resigned from the committee, because he just found our planned recommendation to be too removed from his way of working. Who's to say who's right or wrong? But the point was, we weren't going to just use revealed wisdom from one or two gurus in lieu of an IOM report. That resolved that.

So those are part of the human dimensions to a busy career. But having said this, Dr. Weed and I never did part

as anything less than friends, and still stay on good terms and in touch periodically. I think ultimately, he thought the '91 IOM report was a useful thing to the field. Years later, I nominated him for the IOM August Lienhardt Lifetime Achievement Award, and he got



"I can carve a turkey with my eyes closed." Thanksgiving, Madison, Wisconsin, late 1970s.

Source: Personal collection of Don E. Detmer.



"My mother and I showing off our needlepoint projects, 1981. It was my first such project."

Source: Personal collection of Don E. Detmer.



Souli Souri, Nick Kakiadaris, and Don in Olympus, Greece, 1979. Don was part of the NIH heart team that replaced two of Souli's heart valves in 1967.

Source: Personal collection of Don E. Detmer.

it! That was really satisfying. And I don't think that he ever did know that I was the one that nominated him—certainly, I never told him that. So anyway, I SOAPed [Subjective, Objective, Assessment, Plan] all my clinical notes and kept a patient's active problem list from the time I met him. And I think his point of keeping patient data and knowledge organized was really pure clinical informatics. A record should be able to show somebody what the clinician was thinking, what led them to do what they did, and then also be structured in such a way it could go into a computer-based record. And so I'm extremely grateful to Dr. Weed. To some extent, we've taken his messages—some of them—to heart. His knowledge-coupler is another informatics example, of knowledge management. Very creative man, but a guy who's much more, ultimately, sure of things than I am. I may be an atypical surgeon in that regard. I may be a surgeon, but not infrequently, I'm still in doubt.

So anyway, at the Institute of Medicine, I worked on quality. And it was the first study that the Institute of Medicine did on quality. I staffed it with Karl Yordy's supervision. The IOM was in its second full year of operation. When I took a picture on the front steps of the National Academy Building of the entire staff of the Institute of Medicine, it consisted of just around a dozen people. That was the entire Institute of Medicine staff. John Hogness was president and remained for years one of my mentors.

DS *What year was this then?*

DD '72—'73.

DS *Professor at Duke?*

I SOAPed [Subjective, Objective, Assessment, Plan] all my clinical notes and kept a **patient's active problem list** from the time I met **Larry Weed.**

Karl Yordy was essentially my health policy wet nurse—you know, just taught me about politics and policy in this old apprenticeship **kind of style.**

DD No, no, no, I had finished my residency, and there existed a program at HSMHA [Health Services and Mental Health Administration] called the Global Community Health Fellows program. And most of

the people that went into that program and received funding were training to get, usually, a PhD in epidemiology or something akin to that in order to become international disease folks. So I was really atypical for that group, but they were terrific. It was a career development award program, but I applied for only one year of support, to be an IOM health policy fellow. As such, I became the prototype of the Robert Wood Johnson Congressional Health Fellows Program. I wrote the first draft of that program's grant proposal and did the planning

for it with the Robert Wood Johnson Foundation president, David Rogers, with input from Dr. Hogness and Roger Bulger. Ultimately, it got funded and has been a continuing program at the IOM. Since I was so very early in its tenure, the program's never really,

quote, "seen me as one of its fellows." But in John Hogness' and Roger Bulger's minds, I really was the prototype. And that's why Hogness said when I first met with him the year before, "If you can get the funding, I'd love to have you since I want to have a formal IOM Fellows Program, but right now I don't have the money for it."

So when I applied to the Global Fellows program, it was administered by Karl Yordy, Ruth Hanft, and Bev Meyers.

There was a "bake-off" for applicants, with a panel of people who interviewed you. As it turned out, by the time I arrived at the Institute of Medicine to start the fellowship months later, both Karl Yordy, my supervisor, and Ruth Hanft had left the government, and both were working at the

IOM. It was never really totally clear to me whether they knew they were going to IOM at the time I was interviewed by them or not. But Karl Yordy, if his name isn't known to you, is a brilliant political scientist who went to Princeton. This past year, he was recognized by the Institute of Medicine with its lifetime best staff award. But this guy was great, and he was essentially my health policy wet nurse—you know, just taught me about politics and policy in this old apprenticeship kind of style. At that time, when I went through the literature search and got the entire literature regarding measuring quality in healthcare, it consisted of less than two dozen decent articles. Then I spent the summer of '73 at Harvard Business School, and then moved the family to Wisconsin, where I had a 49/51 [percent] joint appointment in Surgery and in Preventive Medicine, so Preventive Medicine was my tenure home.

The W.K. Kellogg Foundation funded me to start the first master's degree program to teach doctors and nurses management, in the Administrative Medicine Program. The degree idea was an independent dream of Professor Rockwell Schulz, who recruited me via an initial blind letter to Roger Bulger. The Administrative Medicine Program just shut down two years ago, so it had a pretty good run. The American College of Physician Executives used it as its initial core career

That's when I started really engaging seriously with informatics, because you're only as good as your data.

training program. And when I left Wisconsin, after 11 winters, for Utah, David Kindig, who had been Vice-President for Health Sciences at Madison, took over as head of that program. He did a lot of really good work building on what I'd started with Jay Noren. But the Kellogg Foundation gave us three-quarters of a million dollars over seven years to build the program, and the graduates have done many great things.

Meanwhile I was measuring quality as my research area, typically in surgery. So I was publishing about half my papers in the health services research literature and half of them in the surgical literature. One research project actually discovered the heuristic called "ego bias." I don't know if you're familiar with it, but, anyway, that was my primary contribution to the cognitive psychology literature.

While in Madison, I also ran the vascular lab, was a team physician for varsity sports, co-directed the peripheral vascular service, and for a while, was President of the medical staff. In addition, I was Quality Research Director for the PSRO, Wisconsin's professional review organization, and that's when I started really engaging seriously with informatics, because you're only as good as your data. There were lots of population-based data related to surgery. I studied accidental appendectomy in the elderly; I was looking at things like the amputation rates of above-knee to below-knee amputation by



Source: Personal collection of Don E. Detmer.

Don in his office at the Wisconsin-Madison Surgery Department office. He received the Clinical Teaching Award from the Junior Class, 1973.

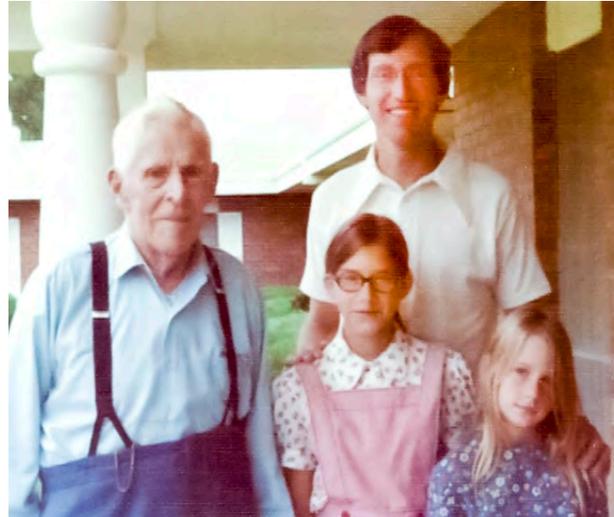


Source: Personal collection of Don E. Detmer.

Venous Doppler study on a patient, University of Wisconsin-Madison. In 1978, Don co-directed the Vascular Surgical Service and ran the Vascular Laboratory.

hospitals and a variety of these kinds of subjects; the effect of age on mortality in surgery; costs of certain surgical signatures on people's use of resources as a style of practice. In other words, a UW health economist and I examined a set of medical records of common, uncomplicated inguinal hernia repairs, and simple appendectomies, and we adjusted the data for sex and age, looking to see if you normalized on just ordinary testing, such as routine imaging and lab studies, how many resources, including length of stay, did the surgeons in the department use vis-à-vis their outcomes? And yes, we found variation.

Teaming up with others, I did some multi-state work on trauma categorization, severity scoring, outcome assessment and improvement, process—some of the really early work in that area. And also, some really early work parallel to Jack Wennberg's small area variations but relating to surgical care. Incidentally, Chuck Lewis, one of my favorite professors at Kansas, published the first analysis showing area-wide variations before Gittleson and Wennberg then picked up on it. I used Medicare data in Wisconsin on some surgical rates. So I got very interested in the population perspective of medical care. I did a paper looking at the impact of state drinking ages and auto trauma, especially because a lot of kids from Illinois were coming up to party and getting wiped out, going south after drinking in Wisconsin. I'd take care of them when on trauma call for the UW emergency room. We figured if we could raise the drinking age, we'd save so many lives. I went up to the state capitol and testified, and we got it raised. We didn't get it raised three years, got it raised two years, and about three years later, we did the analysis, and our original estimates were right on, our estimate of lives saved. It was really pretty satisfying. But anyway, then I got recruited to Utah, and that's really where I met serious informaticians, because of Warner and Gardner and a whole group of those pioneers in the field.



Grandfather Austin McCormick, 100 years old, with Don, Catherine, and Emily, 1976.

Source: Personal collection of Don E. Deimer.

DS To be Vice-President of Health Science?

DD Yeah, I was recruited to run their Health Science Center. I went out there at 45. So I was really atypical. I'd never been a chairman, but I was a full professor. And I'd been on the promotions committee at Wisconsin, and was really very experienced in

academic processes, but I'd never run a department, let alone been dean of a medical school. So I was an unusual hire but these were special circumstances. Bill DeVries had done the Barney Clark total artificial heart procedure, and Chase Peterson was Vice-President when that happened and was on the news all the time. Well, Bill DeVries had been one

of my residents in training at Duke, and so Peterson thought this background could be useful. "I'm going to become the President of the university, here's a Vice-Presidential candidate who's actually had heart surgery experience, and he even knows our young star. Sounds like a pretty good situation." Well, it turns out that about a week after I arrived in Utah, or three weeks after I arrived, I'm on Dan Rather's "Evening News," giving the University of Utah's reaction to Bill DeVries going to Louisville.

DS Yup, I remember that.

DD So while my family members around the country found that really kind of exciting to see Don on national TV, it wasn't the news that Utah wanted to hear. Happily, shortly thereafter, I recruited Bill Gay at Columbia to become Chief of Surgery. Bill had also been at Duke and had supervised both DeVries and me. Bill Gay started a first-rate heart transplant program, which worked in concert with Latter Day Saints Hospital. Because the young Mormons insisted on riding their motorcycles without helmets, we had an ample supply of organs, and being a very socially oriented kind of society, organ donation was seen as a way to help somebody and mitigate at least

some of the tragedy. So, Utah's combined transplant program supplied much of the West of the US with hearts, because we couldn't use them all, and Utah quickly built up one of the biggest heart and solid-organ transplant programs in the country. Dr. Willem "Pim" Kolff was still there and also Dr. Jarvik, so the artificial heart work was still going on, but it subsided and became more of a temporary-assist kind of therapy, which is, I think frankly, where it should have gone in the first place. Time has borne this premonition out as well.

But at any rate, in the midst of this, Homer Warner,* with the help of Medical School Dean Cecil Samuelson, was coaxed to come up to the university from LDS Hospital. It was really the dean's business, but I was very supportive of it,

and I did help get a donor—the May family—to fund a chair in informatics that Homer now holds. Homer came into my office one day and asked, "What do you think of changing the name of the department from Biomedical Computing to Medical Informatics?" And I said, "Yeah, that sounds like a good idea." And so it became the first department in the country, to my knowledge, to be named Medical Informatics.

There comes a point where not all people are going to be happy about things. That's what leadership is about.

DS I was there then. I remember that.

DD It's fascinating, how these things happen.

DS People were angry.

DD Were they?

DS Oh yeah, we hated it.



Source: Personal collection of Don E. Detmer.

Don and Mary Helen Detmer, photographed at their Branch Point farm by friend Don Lindberg, 2010.

JA Nobody knew what it was.

DS “What’s this?! We came here to get this degree in biomedical computing and biophysics, and all of a sudden, what’s this medical informatics?!”

DD Dean, did we even know each other then?

DS Oh, no. I’d hear Reed Gardner talking about you. I met with him all the time. I always remember him talking about this.*

DD That’s really funny, that you were bent out of shape about that.

DS Oh, yeah! Now I’m glad I’m a medical informatics person.

DD Well, that’s part of my legacy, you know, as a change agent. There comes a point where not all people are going to be happy about things. That’s what leadership is about. Sometimes you’re just lucky, too. So anyway, Priscilla Mayden was fabulous, and she was director of the library. I’ve always been a library person. I supported the Slice of Life Project that ran for years—Susan Stensaas—another terrific innovator. In fact, when I was at KU, the Clendening Library was a very good library—one of the best medical history libraries of the world, so I actually got to know the medical historians as well. I always really admired libraries. So Priscilla is fantastic, and she ran a great library. Don Lindberg* came out and gave a lecture in her honor, and I had not met Don. We went together to dinner, his Mary and my Mary—Don and Don, and Mary and Mary—at the restaurant at the top of the Hotel Utah, which is now closed and being used totally by the Mormon church. So we were sitting up there having our wine and nightcaps and talking and really hit it off—such a wonderful guy. For one thing, we agreed that Easy Writer was the best word processing program at the time! I love both Don and Mary, they’re spectacular people. And so the next thing I know, he has me on the

Board of Regents of the National Library of Medicine. Homer and I also worked on an IAIMS grant, as well [for the NLM’s Integrated Advanced Information Management Systems initiative].

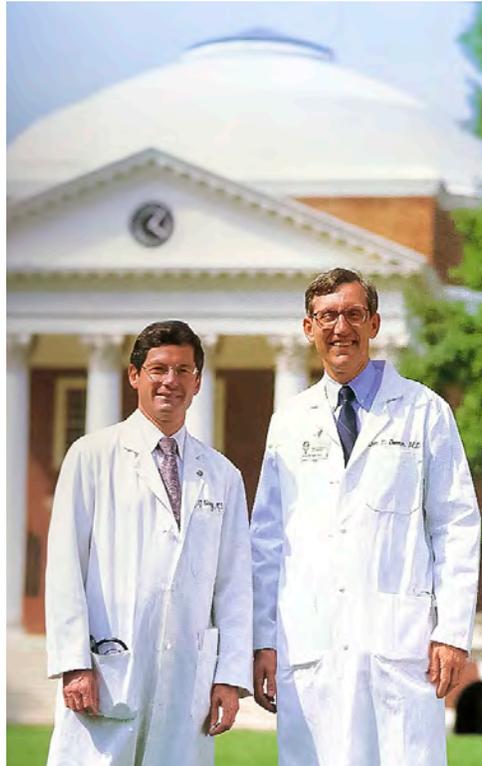
Now, the other thing about Utah I’d like to mention is that we built upon the Governor’s 1982 initiative for a major regional genetic data resource, where we put together databases from the Mormon Church, the state health department, and the University of Utah, for use in genetic research. A tremendous amount of really important early epigenetics research has come out of that. And putting together those data sharing rules among all these groups was a major effort. Happily, and somewhat uniquely, in Utah, you can have church and state kind of blend together with the university and not have everyone pass out about it. But nonetheless, it was a wonderful example of how collaboration can work for the common good. We did have to set up good rules, we had a good board, and the rules and regs worked. I think it really was one of my more satisfying administrative projects. But that wasn’t the big thing I worked on.

The big thing I helped get done out there was moving Primary Children’s Hospital to the university campus. I

led the team for the university side. Folks had talked about such a move for seven years or so, but Dave Jeppson, leading the team at Intermountain Healthcare and I got it done in about a year and a half. I also negotiated with President Peterson a new genetics research building with Howard Hughes funding, plus a combined psychiatric hospital and research building out in the Research Triangle, as well as a family and sports medicine clinic on Wasatch Boulevard.

DS You mean that research park off to the side?

DD Yeah. The latter items were faculty initiatives that came to me for support. But I facilitated these ideas



Dean Robert Carey of the UVA School of Medicine and VP Don Detmer in front of the Rotunda on the Lawn, 2006.

Source: Personal collection of Don E. Detmer.

into reality. So Psychiatric Institutes of America built the psych hospital out there. We also incorporated the Associated Regional University Pathologists.

DS Yeah, our old lab, you mean?

DD Yeah, Dean, that was put together as a company, and it became a reference lab for a lot of the country's high-end laboratory testing. In fact, John Matsen led that and subsequently, about three Vice-Presidents later, he became Vice-President for Health Sciences. A really nice guy and a great head of Pathology. So I had a lot of fun in Utah, and I got a lot accomplished in addition to the skiing and covering Lake Hospital in Yellowstone for a week each summer. I mean, actually, I was only out there in Utah for 4 years, but I figured I got as much done as I would have if I'd stayed there 10, so I didn't feel it was too offensive leaving after 4 years.

Scott Jones, who was at Duke when I was there in surgery training, was at that time the Chief of Surgery at Virginia, and he called one day and said, "Would you come look at the Vice-President's job at Virginia?"

Actually, it's really kind of astonishing. All my jobs have sort of found me, since Wisconsin, which is really pretty nice. Even the Wisconsin job fell into my lap because they were looking for an academic clinician interested in administration. On the other hand, I've positioned myself—I taught a course on managing medical education institutions, so I'd been teaching a course for four years on how to do that, before Utah called. So yes, I'd never been a dean or a chair, but I'd been teaching this content—strategic planning and all that sort of thing. It was a way of "begin doing what you think you'll want to next," and then somebody will call you to do it full time.

So anyway, I went to Virginia.

JA Why?

DD Well, it was an interesting decision. First, they were building a brand new university hospital, so

that was certain to "unfreeze" the Health Sciences to some extent. Plus, I like history, and one of the things they dangled in front of my wife and me was living in Pavilion I on Jefferson's Lawn, within the historic "Academical Village." And to have someone ask, "Who's your architect?" and be able to answer, "Thomas Jefferson," is pretty amazing.

DS Big house, huh?

DD I like to walk to work, too. I walked to work in Wisconsin; I could almost walk to work in Utah.

Actually, I used my moped a while out there, but I'd have to go down to the Park Building, too, so ultimately I ended up driving so I wouldn't be all sweaty for important meetings. But typically, it's really great to get your exercise as part of your day. And I liked the environment. The university environment at Virginia really is nice.

But in a way, Virginia was a surprise for me.

In fact, I kept saying,

"Why do you folks want me? I am not really your kind of guy." I mean, basically, the joke goes, how many Virginians does it take to change a light bulb? One to change the light bulb and two to talk about how great the old light bulb was. That's not really quite the cowboy style. There is an element of the farmer part, but they are mostly gentlemen farmers. So anyway, they insisted that they wanted to change and needed to change, and they needed that kind of leader. Anyway, they wanted me, so I went.

Plus, the proximity to Washington was good for me, because by then, I was really starting to be pretty heavily involved in policy with the Institute of Medicine, and with the National Library of Medicine, and it was just great, because Washington was not that far away. So in Christmas of '87, we moved to Virginia, and I guess that's the start of that phase.

JA They were already doing quite a bit with hospital information systems?



Source: Personal collection of Don E. Detmer.

UVA Pavilion I annual student pumpkin carving party, hard at work, circa 1989. "We gave out 100 treats to trick-or-treaters at Pavilion I's front door in 1989, and over 1,000 in 1996."

DD Not a lot, but some. I mean, the point is, they had a trajectory in mind, including physician order entry. But it was pretty apparent—in fact, it was really sort of funny—it was presented to me at the time as though all their planning and strategic work was in line, and it was just a matter of playing this thing forward and on out. And certainly, I'd heard about CPOE [Computerized Provider Order Entry], and I was enthusiastic about it and more than marginally supportive. But it was made more interesting, because of the prior IAIMS work with Homer. Homer and I even authored a paper advocating for both a policy committee and an implementation or operations kind of committee if you were planning on being successful. So I actually was able, I think, to improve some of the way we went at it in Virginia. But basically, I was the Health Vice-President, I wasn't really down in the trenches doing the change itself. I had deans and the directors reporting to me, so there was the org chart phenomenon. Happily, I had recruited Linda Watson for the library, which was a great recruitment. And I recruited Jeannette Lancaster in nursing, who's also still there. And Bob Reynolds, who also had been at Hopkins, and he had really done key things there. Bob became my right-hand person, and he certainly did know some IT and informatics, so while I was looking after all the Health Sciences issues, Bob was helping on the informatics/IT side of the job.

The main immediate task facing me was to complete the financing and construction of a new University Hospital. It was the state's largest construction project to date, \$230 million, 19 football fields' worth of square feet, so it was a big deal. When we finished it on time and on budget, I was also successful in getting another floor and a half added so that we could move the women and children to the new hospital, too. The women's and the children's wards had been left behind in the earlier planning. And I figured that since we were building at the time, we could go ahead and get the additional space added to the project in there and probably pay the added space off in a few years. In fact, we paid it off two years early, by moving all hospital operations at once without duplicated labs.

Well, we got into the order entry business in the early 1990s. Actually, implementing IT or making

We got into the order entry business in the early 1990s.

another major change includes a key piece that I had learned even while in Utah: if your department chairs aren't with you, particularly your key clinical chairs, you're not gonna do anything. And so the first thing was to get the clinical chairs all lined up, and they said they were definitely on board—that is, as it turned out, until their residents started complaining. And then Medicine blinked. The Pediatric and Surgery chairs were holding the line with their residents and faculty, and the others were as well. But Medicine was starting

to say, "Well, gee, we didn't realize it was going to make our house staff do their work a different way." Now, it was clear that even among the medical residents, there were some that were not outraged about it. Okay? But there were clearly enough who were very aroused, and when

the department head starts backing off, obviously, you've got a very different game on your hands. So it escalated to where I had to step in myself.

One axiom I'd learned from years of senior academic administration is that the trouble with academic center decision making isn't that they cannot make decisions, but rather they have a real hard time remembering the decisions they have made. After counting noses, I chose to stand firm. We had made the decision, and we were going forward with it. And so, ultimately, when I had my rather pivotal meeting with the house staff, my speech followed this theme. "You came here to be trained. My sense was you didn't come here for you to train us. CPOE is something that isn't perfect, but you can and should help us make it better. And at least you will be part of working toward the future, not a part of thinking and sitting there and eventually having to do this late in your career—because it's coming. And we're gonna do it!" And I didn't offer that speech without knowing that Peds and Surgery were still solidly behind me. But at that point, it got some print in the newspaper, and the newspaper really clearly didn't understand it, but they said, "Computers seem important to healthcare. While we don't know what's happening over there, we hope you can sort it out and get going soon." And so, ultimately, that was the kind of coverage we got.

An academic paper was later published about our experience that it made it sound like it was a failure, when actually [I think we succeeded because] we got the change through the pipe. In Virginia, no

change goes down that simply, at least anything of any significance. Okay? Because that's actually in the nature of the Virginian culture. In fact, part of my reaction, as I mentioned earlier, when Virginia first called me to visit Charlottesville and look at the VP job, was surprise, with me being a Kansan and clearly being change-oriented by disposition. So Mary Helen decided that she would accompany me to Charlottesville but not as part of the formal visit. She would come essentially incognito. I said, "Look around this place. If you're not interested in moving here, we certainly don't need to, because it's not like we're being run out of Utah. Plus they may not prove to be interested in me, anyway, but you'll have seen the place on your own schedule." That evening she said, "If they want to talk further, keep talkin'." We still live there; our farm is northwest of town near White Hall.

The UVA CPOE story is really a change management issue at the end of the day. And, obviously, sometime later, you, Joan, came to talk with me about it, and we've been talking on this issue indefinitely over the years. It's fascinating how the issues remain the same—nothing new there. The same sorts of elements play up. But to succeed, that is, to get the change implemented, you've got to have leadership, and you've got to stick to it, too.

Now, on the other hand, you also have to yield, you have to help. We said at the outset, "We're not doin' this as punishment. If you have suggestions—what would help you?" "Well, little printout sheets at the end of the day could tell me where all my patients are in the place," and that sort of thing. Order sets. So we just let them write any order set—"You can write any order sets you want." After many months, it seemed like we had a gazillion order sets. And once we got this CPOE pig through the snake, then we came back to them, offered free

pizza to have rising residents compare all the order sets against the best clinical evidence. We trimmed the order sets down pretty aggressively that way, and also experienced a positive cultural effect, because then the bedside rounds conversation became a situation

where the attending might say, "Well, why didn't you order such-and-so?" And the residents would reply, "Well, we just went through the literature, looking at that order set, not too long ago, and we found there really wasn't good evidence to support doing it. If you know otherwise, fine, but in fact, there's a couple of new articles—."

So, the dialogue changed from the old kind of traditional authority source to the strength of the scientific evidence. This is really something compelling to see. Life can be amusing. About three years later, I was on an airplane flying out of Charlottesville and there was a young woman sitting next to me who said, "You're Dr. Detmer, aren't you?" I said, "Yes." She said, "I just wanted to say hello. I understand that you had something to do with us getting computer order entry

into the hospital. I want you to know I'm flying out to the West Coast looking at residencies, and I'm only looking at places that have computer-based record systems, because I don't want to have to start all over without it. I just want to thank you." That was so funny! I mean, it was so ironic, in the wake of the emotions just a few years earlier. Also, a few surgical residents from that era became surgical informaticians

as well as lifetime friends.

JA Something I want to ask you about: I talk to a lot of other people, too, who were there at the time, and I was told that one of the secrets to the ultimate success was that you actually sat down—was it a weekly basis?—with the residents.

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DD I did for a while to make certain I heard their concerns clearly and could help make it easier for them.

JA And worked through the issue.

DD It wasn't always that we could help, necessarily, but I mean, I was saying, "I'm there." Interestingly enough, I did that with the community, too, the people who lived around our community. There was such hostility from neighboring people to the hospital, and particularly from those in the very poor predominantly black neighborhoods. It turns out, for example, our Pegasus helicopter was flying right over their homes at all hours of the day and night. Instead of flying over the Lawn, where I lived—you know [imitates sound of chopper], it was going routinely over those folks. Well, they brought this item up, and I said, "I think we can fix that." Within a week, I'd changed that, because some stuff I couldn't change, while some stuff I could change. Sometimes it's good to be king! Anyway, initially, they couldn't believe that it worked. So over time, I think they were sort of saying, "Okay, not all their actions are being done out of meanness." I mean, it may feel like punishment, but it became a revelation. And the new attitude wasn't too long coming. I mean, we kind of, I think, convinced people that we'll work on issues, and we'll work on them together. I think, actually, that working together part was part of it. It made for both a happier place to work and a better place to live.

JA I love that story. I'm going to turn it over to—well no actually, I should probably be the one to ask you about IAIMS. Is that okay? Because you were the PI [principal investigator] for IAIMS at Virginia. And my question is, how did that all start, and how did it turn out?

“I’m only looking at places that have computer-based record systems, because I don’t want to have to start all over without it.”



Don and his mother enjoy fishing the pond, 1990.

DD Sure. Well, I think actually I left the VP job before it was over. But when it started out, I'd have to say, Linda Watson and Bob Reynolds were pretty key in our decision to want to do this. One of the questions that I asked when I first got to Charlottesville was, "What are the health problems of the communities around us?" And no one had any idea. So I paid some money to a team to do an epidemiologic survey of all the little communities around Charlottesville to determine their main health issues and what their information needs were. Also, Linda Watson was interested independently in creating some outreach to Southwest Virginia, as well. So we were interested in looking at the IAIMS from a perspective more, if you will, than just the inside academic institutional initiative, in the narrowest sort of way. I was probably influenced a little bit by the Wisconsin idea, where the borders of the university are considered to be the borders of the state. You know, UW-Madison is a land grant college, and that was its mentality—definitely not strictly Jeffersonian, in the strictest sense of the word. Jefferson started his university—the University of

Virginia—to assure that meritorious individuals could be equipped with “useful knowledge” to assure the success of the Republic as former students played out

Source: Personal collection of Don E. Delmer.

their civic roles but not necessarily focusing on the Commonwealth of Virginia per se.

Linda sat on my senior executive group, which was pretty unusual, for the librarian to be part of. And she was fabulous. She would sit there oftentimes very quietly and then raise three unbelievably salient questions that no one had been thinking about. Anyway, we went after an IAIMS grant, and part of the reason is that we wanted to be able, hopefully, to tie databases and knowledge sets together that were in some instances sitting around the place, but try to actually put them together in a way that the data could generate “useful knowledge.” And it was a very, very traditional silo kind of academic health center at that time. We just did not have that much intra- and extra-institutional data sharing. Having said that, it had one of the best and earliest unified clinical practice plans in the country, and that was one of the reasons I took the job there, because it was really spectacularly well developed. It was a group in that sense, although the nursing school was quite off to the side. But the clinical unified practice plan was quite unusual, at that time; the departments did all share data and also work together on common billing and those sorts of things. Anyway, the IAIMS was an opportunity to be more academic in our way of doing cross-institutional work and trans-regional in our thinking, and it helped to put the library at the center of things. The sense from all the deans and directors was, “Well, it’s probably smarter coming out of the Vice-President’s office rather than the Deans’ offices.” In that context, I was very lucky. The Dean of the medical school who I inherited, a fellow named Robert M. Carey, was a terrific guy. I mean, really a terrific guy. We never had ego problems. And unfortunately, Virginia had had that problem in the past. Carey, Lancaster, Halseth, Watson, Reynolds, Ashley and I always worked together extremely well. So we were a solid team. In fact, we had a reunion one Sunday together, last summer. It was the first time we’d all been together. Ashley came up from New Orleans, Halseth down from Winchester, Virginia and the rest of us were still local. And that group, we just spent most of that whole day talking about our fun

Ed Hammond likes to reflect that that was the first time he’d ever heard someone talk about a computer-based personal health record.

times together. We worked extremely hard, and we made some genuine progress. And so anyway, I think that was really the story. But I have to admit, I’m not sure that we accomplished a great deal of cultural impact.

I did do a lot of very valuable conceptual

thinking that, when it then came to a National Health Information Infrastructure and National Committee on Vital and Health Statistics, I had developed a conceptual architecture in my mind that really allowed me to just plow right ahead from a national leadership perspective once that opportunity arose. I gave a talk in September of, I think, ’95, to the IAIMS consortium meeting at Vanderbilt and laid out, essentially, the components

of an NHII as I saw it.⁵ And that talk was published in a supplement of JAMIA laying out the model of computer-based patient, personal, and population records. Ed Hammond likes to reflect that that was the first time he’d ever heard someone talk about a computer-based personal health record. And then, of course, I was asked to chair the IOM study on the Computer-Based Patient Record from 1989 to its release in 1991.^{6,7}

When I left the VP job for a sabbatical year in 1995, I’d been a Vice-President for a dozen years, and I was getting bored with myself. Too many issues just seemed like rehashes of past scenarios and were not exciting enough. Some colleagues thought that I was totally nuts to leave a Vice-president position, but I figured if the water closes behind me after I leave, it closes behind me, but I just have to find a way to become more interesting to myself. I had gone through my five-year review two years earlier and had been reappointed for another five years. I talked to President Casteen at the time of my renewal. “In my seventh year, I’d really like to take a sabbatical.” I said in effect, “You know, I realize that a sabbatical from such a post is pretty unusual, and if life moves on, it just moves on.” I had every expectation to come back, so I took the leave in good faith. And I think they did it in good faith that I would come back. But as it turned out, things did move on, and Bob Cantrell became the VP for Health. So when I came back, I came back

as Senior Vice-President after the sabbatical year at the High Performance Computing Lab at the NLM with Don Lindberg. Amazingly, I stayed in the same apartment (310) in 120 Center Drive that our family had lived in in 1967-'69. The flat had been furnished for Harold Varmus before he moved full time to the NIH, so it was available. The next year, the entire building was razed to make room for an extension of the Clinical Center. When I first arrived at the flat, two large pictures hung from the walls: a picture of Baltimore Harbor was in the living room and one of Monticello was in the master bedroom. It was a bit surreal since I'd come to NIH from Baltimore the first time and back to the same flat from Charlottesville the second time.

On Arbor Day 1996, I met with Senator [Bob] Bennett about sponsoring a confidentiality and security bill. The bill he dropped became SB1330. It didn't get out of committee despite bilateral support, because it was torpedoed without prior notice in front of the full Health Finance Committee at the last moment by a young privacy fundamentalist who had worked for months with us on the bill. Had it gone forward, America would have had much more decent legislation today than HIPAA, with far less damage to research progress. We saw—and I think it's still true—this country doesn't need privacy legislation, it needed confidentiality and security legislation. Privacy has no clear meaning upon which to build sound policy. And Senator Bennett was very approachable—I'd gotten to know him and Senator [Orrin] Hatch a bit when I was in Utah. And he's a great guy, he's a totally straight shooter, really a nice man and competent Senator. And he had been involved during the Clinton health reform struggle. The only thing in the otherwise unsuccessful Clinton health reform idea that didn't cause any uproar was the health data privacy part that even included personal health identifiers. So it looked in prospect like that piece could be taken out, and with some minimal changes, would go through the next Congress in a breeze. Well, of course, when viewed in hindsight, when everyone hated every other part of the Clinton bill, they had to find something in the thing to think was not so bad. And so, quite falsely, a number of us assumed that people were okay about privacy legislation. But once that became an issue only in and of itself, all the bets were off. You start all over at ground zero, and the privacy fundamentalists really got into the thing, some virtually glowing in the dark about it, and it really changed the whole configuration

of the debate. We went to HIPAA regulations as the answer, which is another complex story. The Congress never could deal with it, so it punted it to the Executive Branch to work out. What happened, as is often the case with policy, you end up with so-so outcomes. Having said that, Bill Braithwaite and Betsy Humphreys* and a few others did the nation a service by at least getting some real sense into the HIPAA legislation, where otherwise we wouldn't have had anything workable today. But it was very frustrating at the same time. I related closely to the late John Eisenberg when we came down to writing the HIPAA regs—because I was chairing NCVHS for [HHS] Secretary [Donna] Shalala at that point, and I was sitting in the department's Data Council. For being both a brilliant academic and a wonderful person, John never had a feel for informatics or its potential. Don Lindberg and I tried to enlighten him but really to no avail. Prior to agreeing to chair the NCVHS, I negotiated almost two years before I said I'd do it, because I wanted to make sure if I was really being asked to change the NCVHS, that I would have both sufficient authority and the financial support to totally remake the role of the NCVHS into the nation's health information policy advisory group rather than dealing simply with vital statistics. But all this is five years ahead of the IOM CPR [Computer-Based Patient Record] Report story.

DS You mentioned a little bit about the 1991 Institute of Medicine Report on the computer-based patient record. I'd just like to know sort of how you picked those committee members, how that project worked out.

DD Sure. That was really an exciting thing. In a way, that was my first big, if you will, ask by the IOM to do something substantial. As I recall, I was chairing the Board of Regents of the NLM at that time, and Queta [Enriqueta] Bond is the person who led to the study getting done. Queta was the Number Two person under President Sam Their at the IOM. And Queta—I don't know if you know Queta—she's fabulous, she currently runs the Burroughs Wellcome Foundation. As it turns out, she grew up in Charlottesville. I didn't know that at the time, but we've become very good friends. She's a member of the Blue Ridge Group, and is just terrific. But at any rate, I think it was in 1987 or '88, Don [Lindberg]* and she had stimulated creation of a small working conference at the National Library of Medicine on electronic records. And the

sense coming from that meeting was that it would be good to do an IOM study. This study became the first internally generated study that the IOM undertook.

DS Is that right?! They haven't stopped since, have they?

DD They've done a number since then. But at that point, they had never done one fully internally generated, at least to my understanding. The others were done at the request of Congress or occasionally foundations or agencies. Queta asked me if I'd chair it. So between us and Don Lindberg, funding was sought, and finally the committee was put together. Paul Tang was then working with Hewlett Packard and did a terrific job rounding up a great deal of the funding. There were a lot of the key people on it and also on the subcommittees. The way we structured it, we broke it into three groups, and we had one group on users and uses, one on technology, and one on implementation and strategy. This was very unusual, for an IOM study to talk on day one about, "Well, how do we move this forward after the study?" So, Don Berwick, the current

guru on quality improvement, chaired the users and uses group with Carmi Margolis, a visiting scholar from Israel. Ted Shortliffe and Paul Tang took on strategy and implementation, and Morrie Collen* and Marion Ball did the technology honors.

We then fanned out, as we did the process of that study, to talk to a lot of people, so by the time of its release, rather than having engaged only the dozen members of the committee, the report actually had been vetted and gone through, even before it went through formal review, about 150 people who had actually touched its substantive issues. And that was part of my strategy. I really wanted to have something that would stand on its own but also would have gotten enough people in play that by the time it came out, people would be interested in knowing about it. Now, Ted Shortliffe, in particular, strongly advocated for a Computer-based Patient Record Institute, a formal organization to further develop our ideas, and that took a lot of doing, to get that recommendation through the IOM. The Academy reports normally don't approve recommending new organizations as part of a report.



Source: Personal collection of Don E. Detmer.

Marion Ball, Peter Pronovost, and Don Detmer at the American Academy of Nursing Fellows Dinner, 2010.

So that took quite a bit of energy, but Ted hung in there on that, and basically, that went through.

But I think one of the most interesting things in that report was we specifically didn't call it an electronic

medical record report. In light of all the patient-centered-care focus today, we turned out to be well ahead of our times.

And the reason why we got around to CPR? Morrie Collen originally was saying this is computer-based rather than paper-based and that the focus must be on the patient, rather than who puts the information into the record. So we don't want it to be a medical or nursing record—it's really a patient record. And so we coined the CPR term, which at that time obviously meant cardio-pulmonary resuscitation to most folks and caused a fair amount of discussion and discontinuity here and there. Basically, the new term served its purpose for a while, in that it made clear that we weren't talking about just sort of taking the current thinking of a record, running a paper record through a computer, to come out with a computer-based record. No—we were talking about decision support. We were talking about being able to use it for a variety of new kinds of uses—a totally re-envisioned health record.

With the reissued report in 1997, it became one of the National Academy Press's most popular releases. So anyway, The Economist some years later said that the CPR report moved the computer-based record or electronic health record from a dream of a few enthusiasts to being an establishment goal. And, I think they got that right. While it kind of stalled there for a long time, we made our mark. It was only later when I chaired the Board on Health Care Services that policy for EHRs moved forward.

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JA How did that happen?

DD The Board on Health Care Services (BHCS) in the IOM is the board charged to cover all policy

aspects relating to healthcare delivery and financing. While I was chairing it, and I chaired for 8 years, I met with the IOM Council, who were really wanting to do a series of reports relating to quality. While there was some interest in the Board of Health Services relating to quality, when I met with the Council, I said, "Look, if we get into this, the focus should be not to talk about quality per se since everyone believes in quality as a good thing. We need to focus on making serious major threshold improvements in quality. Because you can always talk about quality and who's to disagree? Quality's just great. Who doesn't want it? But one percent quality improvement is not worth our time. If the IOM is going to get into this, it needs to get in it to say how we're going to make major threshold changes." The Council approved a series of quality studies, and I became the liaison to those reports and sat on the committees where I could offer oversight and input through to the Board on Healthcare Services.

Another series of reports I feel very good about from my period of BHCS chairmanship was the whole series of reports on health insurance and access to care, on equal access and under-insurance as well as the impact of lack of insurance—that is, a series of reports to cover any and all aspects relating to how our current "non-system" was performing with respect to access, affordability, and insurability for all Americans. I don't know if you're as aware of those reports. They're very, very good reports, and

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almost all were completed after I'd left the Committee as its Chair.

But anyway, the To Err is Human [IOM] report came out first, in 1999,⁸ and it didn't have anything to say about IT or informatics in it. It just said, "We've got a big problem in River City." And that report was a real potboiler, even before we came out with it. In the review process, there was a lot of concern that the report would cause a panic in the public mind, and also that docs are hard-working well intentioned people who shouldn't be undermined, and dah-dah, dah-dah, dah, and the report makes it look like all health professionals are dopes who don't know what they're doing and that we even may want to hurt people. So we went through a lot of angst prior to the report release. Our big concern was the issue of marketing the report accurately to avoid misunderstanding its central message. Historically, the Institute of Medicine had never really worried about the PR [public relations] side of its reports. The National Academy was more like a Delphic oracle and just said its things, and, supposedly, the world would pay attention or not as the case may be. But for the errors report, we tried to round up a number of the top health reporters in the media, both print and television, which isn't easy unless you get one or two top ones to come—then they all come so they don't miss out on anything. Anyway, we got them to come and spend a day with the

We need to focus on making serious major threshold improvements in quality.

committee seeking their advice after we'd described the report's thesis.

So, we got them in the tent, and we said, "We have this message that's a pretty strong message." Basically, their message of the day back to us was, "Forget it. Buy advertising space. If you want to get your message out, buy the space and put your story in the papers." And one guy said, "This is a thumbsucker." It is the kind of story to take to bed with you, because about two minutes into the thing, you fall asleep. And he said, "This doesn't have sex or sizzle." He said, "If you can somehow make it sound interesting—." So before we went public, Lucian Leape came up with the metaphor of a 747 crashing. At any rate, once the report was released, the impact was amazing. We had

all gone away feeling terrible the evening after we'd met with the media, because we thought, "Well, cripes, it's hopeless with these folks," because we'd almost pled with them. I mean, this is really important to the American public. And they're all like, "This will not get the interest of our editors." Anyway, lo and behold, when the report came out, they had all heard about it from our briefing and had heard our pleadings. They had had a full-day confidential briefing on it, and the media folks were really quite worked up about it once it hit the street. And so suddenly, they put all kinds of ink to the reporting. It was really interesting, because I don't think we co-opted them with our approach; it's just dumb luck, probably. And you know that report



Source: Personal collection of Don E. Detmer.

Walsh McDermott Medal presentation from IOM President Harvey Fineberg and Home Secretary Stephen Ryan, 2009.



Source: Personal collection of Don E. Detmer.

Don with informatics students in Taiwan in October 2009.

got more ink, by far, than any up to then. And it was all actually due to that media retreat, which initially seemed to be a failure to us.

We then moved on to the Chasm report. Bill Richardson was an excellent chair for the entire quality-of-care-in-America series, and David Lawrence was brilliantly key to the Chasm report. At the time of the Chasm report, he was head of Kaiser Healthcare.

So anyway, his point was, we basically still have the chassis under healthcare we've had for a hundred years, and we've got to really get a whole new infrastructure under this thing for it to move. And hallelujah, he was absolutely correct. And, obviously, Don Berwick was extremely strong, and also Lucian Leape, but many others as well.

This was a very good committee. But the one thing I did get into the report was the role for information technology. I was rather surprised at how willing they were to let in pretty strong language—I mean, essentially, the message that you're not going to get to this new promised land if we don't go at an IT infrastructure seriously. And so in editing, I spent a lot of time on that kind of language. And I wasn't the only one, but I was one of the key ones that did it. And when that report came out, it, too, got a lot of attention.

DS Well, David Lawrence at Kaiser was spending a lot of money on IT [information technology] then.

DD Exactly. He was terrific. Anyway, we ended up coming out with some really strong recommendations, really, about IT. And at that point, I was in the policy mix both at the IOM and via the NCVHS. [The National Committee on Vital and Health Statistics (NCVHS) is an advisory body to the U.S. Department of Health & Human Services (HHS).^{9]} With Secretary Shalala changing NCVHS from essentially what had been a vital statistics reporting committee—honorable,

very good, historically very valuable, but it was in a lull. So I was recruited to lead that change—she wanted it to become the nation's primary Health Information Advisory Committee, a role it played for the nation until the ONC [Office of the National Coordinator for Health Information Technology] was created. The NCVHS literally changed its role. This perspective for reframing the committee emerged

from our year plus of discussion. Jo Ivey Boufford was the key person who I negotiated with in Phil Lee's shop. [Dr. Jo Ivey Boufford served as principal deputy assistant secretary for health in HHS from 1993 to January 1997 working for Assistant Secretary for Health Philip R. Lee and Secretary Donna Shalala. From January to May of 1997, she was acting



AAMC President Darrell Kirch and Don ready to fish the James River, 2009.

Source: Personal collection of Don E. Delmer.

assistant secretary for health.^{10]} She's a really sharp gal. I don't know if you know her, but she's terrific. Anyway, I ended up chairing that reformation, and then obviously worked a lot with [Dr. John] Eisenberg and also created the [National Health Information Infrastructure] NHII working group and chaired that work group myself.

The NHII working group built off the model that I'd talked about at the IAIMS presentation—the diagram of personal health, patient, and population records as an information architecture for the nation's health. Didn't know any better at the time, and it was probably okay, but in retrospect, you always wish you'd done some things different. For example, I should have argued for some dedicated dollars for the Data Council to have to implement some of our multiagency collaborative ideas. Also, I didn't really put sufficient emphasis on research and education in the original NHII plan.

Subsequently, I wrote a paper in Biomed Central that has been picked up on by some folks, which talked about the “missing” research agenda.¹¹ I need to find the time to write the education agenda piece.

And it's fascinating. Just now, we're working on the workforce issues. So it's still frustrating for me that the model NHII, you know, omitted education and research. AMIA is currently working with AHIMA [American Health Information Management Association] for a retreat on workforce issues. But the informatics and ICT education agenda really has been shortchanged in the thinking at the national level, because it focused essentially on patient care and a bit on public health and didn't reflect on the research and the education domains. So in a way, there needs to be a three-dimensional model that would have education and research as part of the original construct. Had education and research been included, it probably would have been too complicated

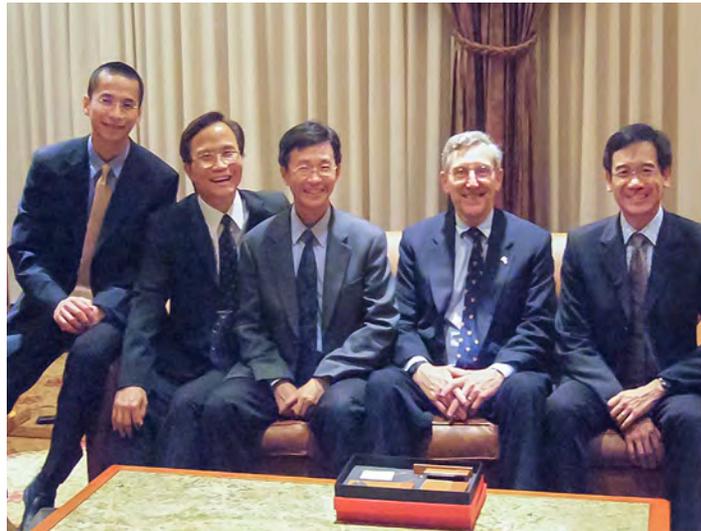
for folks to follow. In a way, the simplicity of the communicating for the health model got a key idea across, and I think got some things moving. So you never know for sure whether you should have done it one way or another. Policy work is both interesting and highly unpredictable. I did mention both education and research in my paper at Vanderbilt. But, we clearly did get the NHII thing going.

One conclusion of the 1991 Institute of Medicine CPR report was that the confidentiality and security issues could be the biggest limitation of not getting EHRs accomplished at the federal level. So that's when I decided, "Okay, well, I'll work on that piece first and try to get something going, and then we can move on from there." That is why I then approached Senator Bennett to sponsor a bill. Well, that saga ended up taking a lot longer and got into so much just nonsense from the privacy community that eventually, I went to Cambridge in England for nearly five years. No! I did! Actually! I became the inaugural Dennis Gillings Professor of Health Management in the Judge Business School at Cambridge and was a trustee of the Nuffield Trust in London. I went to England at the end

of '99, and among other things, actually reviewed their information for health strategy for the undersecretary of Health in Parliament. I also became a consultant to Hong Kong on their IT infrastructure and did some work on patient information with the EU. For about five years, I got very much in the British swing of things, which was very educational, and clearly, as you could tell from my comment this morning, it changed

my way of looking at these issues.

For some time, I was engaged in IT policy work on both sides of the Atlantic. For example, I sat on the PETAC [Pre-Engineering Technology Advisory Council] IT advisory group while over there. When I got back from the UK, I thought I was going to do farming and riding—my horses—and instead, Charlie Safran came



N.T. Chung, other Hong Kong Hospital Authority informaticians, and Don enjoy time together, November 2006.

Source: Personal collection of Don E. Detmer.

after me. We talked for a while about my leading AMIA, and it looked like a wonderful opportunity. In retrospect, all of us wish that AMIA had made such a move a few years earlier, whether it was with me or somebody else. But in any event, I'm having a lot of fun at the moment as the President and CEO of AMIA. The issue is whether or not we can really boost informatics into very different space from where it's been. The early days on the job have gone well. I also have a seat on the Systemic Inoperability Commission, as the nominee for the Speaker of the House Dennis Hastert. The outcome of the Commission's work might have been different had Tommy Thompson not left as secretary of DHHS.

I do have a Tommy Thompson story that's interesting. It relates to standards policy and shows you how a lot of boring committee work can at times really pay off if you get to speak directly to power and you get heard clearly. I referred to him as Tommy Thompson rather than Secretary Thompson—don't want to be disrespectful, although he's sort of a Tommy Thompson kind of guy, if you really know him. I mean, that's how he talks about himself. He was

a prior Wisconsin Governor, as you know, and is quite approachable. Where was I? I kind of got off my line of thinking.

JA AMIA, the Interoperability Commission, or standards?

DD Oh, I know! Let me finish the commission lesson and then describe the standards story. While the President's Interoperability Commission was named by Tommy Thompson, the work was done in the second Bush administration, and a new Secretary came in. Tommy Thompson was an enthusiast, but he didn't really understand IT. Meanwhile, the new Secretary absolutely understands it, really understands it, and he's been both a governor who supported health IT out in Utah and a successful voice in the cabinet. Having said this, he has been unable to get more funding behind either EHRs or the NHII.

JA Leavitt?

DD Yeah, Mike Leavitt. And so I think with him we ran into a very different space. Systemic interoperability was "out," because it didn't start on his watch despite its importance. So that report

became one of those Commission reports that sit on a shelf. Literally. I do want to come back, though, to the story relating to Secretary Thompson. When I chaired the NCVHS, we started working on developing sets of standards, and they weren't approved and moving; they were sitting there in the bureaucracy without being approved and implemented by the government well after I got to England. Anyway, I was asked to come back from England to participate in a retreat with Secretary Thompson. Some weeks earlier, Ken Shine, who at that point was President of the IOM, had gone to visit the newly appointed Secretary Thompson to discuss important health policy issues. To the best of our knowledge, Tommy Thompson didn't know about the IOM, he'd never heard of the IOM. After he had heard about the IOM and its work, he said, "Well, golly, you folks should give me five or six things I should work on while I'm Secretary since I won't be here that long. That'd be really good. Why don't you get together a few of your people, and we'll just have a day face to face with them where they can inform me about key issues?" So Ken picked about five topics. One of the topics was the IT infrastructure for electronic health records and policy issues related to



Source: Personal collection of Don E. Detmer.

Don and fellow Past Chairs of the National Committee of Vital and Health Statistics (NCVHS) -- Judy Miller Jones, John Lumpkin, and Ron Blankenbaker -- at the National Academy of Sciences.

the NHII. Molly Coye was invited to be on that panel. You probably know her, since she has been involved in a lot of the quality studies over the years as well as being an expert on innovation in medicine. She and I had sat on the China Medical Board of New York at one time. But at any rate, she is a very brilliant woman—fluent in Mandarin, among other things. The second person was John Lumpkin, who became the chair of NCVHS when I left for England.

So there we were, the three of us, sitting in the NAS building around this little table, even much smaller than this, with Secretary Thompson and John and Molly and me. I started off the conversation by saying, “I would like to just make a point about standards. I just flew back from England to be here for this meeting last night, and this is a piece of paper that’s considered a regular piece of typing paper, they call it AA. And this is a piece of paper that I picked up this morning as I came in to talk to you, and it’s called 8½ x 11.” I said, lifting my left hand and then my right hand. “Here in the US, we call this standard paper, but there they call that standard paper. Every single printer that Hewlett-Packard or any other printer company makes has to have a little slide-adjustable tray in order to accommodate those two standards. Now, wouldn’t it be nice if there were just one international standard so that the extra costs could be eliminated?” Those are standards. Anyway, he got it. So, then I said, “You know, with all due respect, when I left chairing the NCVHS, I had a number of such standards approved that I sent in to the department, and John—correct me if I’m wrong—but none of those has really moved on out, have they?” And John Lumpkin said, “Well, no, they haven’t, Don.” And so Tommy Thompson said, “Is that right?!” And he wheels around in his chair to face Tom Scully, head of CMS, and says, “Scully, is that right?” And Scully says, “Well, yes sir, I think that is right.” And he says, “Well, I want something done on this by the end of the week, or you’re fired! I don’t want you folks going back home tonight. I want you to come up to my office first thing in the morning and sit down, and I want you to tell me what we ought to be doing in the next few weeks. And I’d like to get some information on what I should do right now, and what I should get done in six months.” So I was going to fly back to England that night, but I changed my plans and made the meeting the next morning.

It was really interesting! Anyway, we created a couple of letters that came up to him through NCVHS, through John. But that’s how Secretary Thompson got

moving on standards. And so finally, we started seeing these standards come through.

DS When you say letters, those were the reports on EHR functionalities?

DD Well, no, those were different. But the letters did give rise to interest in new standards that were needed as well. One of the things that we said in the second letter that was sent to him described a need for a functional description of EHRs and what are the functional requirements for EHRs. And so his response was, “Well, it’d be good if the IOM could do that.” To get a new IOM committee started, to do that, boy, it’d be forever, at least months, and we wanted to be very responsive, since the IOM already had a related study under way. And so we said, “Hey, we’ll talk to Janet Corrigan, who’s fabulous.” Paul Tang and Molly Coye were chairing that project. And so we said, “How about you guys do this as a side project within your study? It relates to it, closely enough to match your mandate for your study from the IOM structure, and if it’s not pulling wool over anybody’s eyes, can you accommodate it?” And so they then quickly pulled it together, and that became the letter to the Secretary on EHR functionalities.

DS I don’t know how you’re going to answer this, but you just talked about so many things you’ve chaired and been in charge of so many different projects, I’m just wondering what do you think it is about you that allows you to be successful in these chairing positions? It’s amazing.

DD I don’t know about that, but I think actually I’ve been very fortunate. A lot of it’s just timing, I think, too, and how it works. I mean, the new academic chair in Cambridge kind of fell out of the sky. These things sort of fall out of the sky. But, I would have to say that I did have a crucial experience years earlier—have you ever heard of the Tavistock Conferences?

JA Uh-huh.

DD Well, they enlist a dozen or so volunteers to participate in the conference. When you get into the room with these folks you’ve never met, they announce to you that, “You’re going to spend a day and a half together, and you folks need to decide what you’re going to do with your time together.” Have you done that?

JA No.

DD I did that once, at the time I was a Young Turk Assistant Professor at Wisconsin. And I learned something really important out of it, just about me. I had people really angry at me at the end of that day and a half. It was really very astonishing, because it came out in this encounter that was part of the wrap-up of the conference, where everybody talks about what happened, what didn't happen, and what could have happened. And there was a general consensus that people there were really upset with me because I didn't step up and lead the thing. They said, "If you had done it, we would have been there. We'd have done anything, gone for a walk, or whatever, but you just never did," and people were really angry. I mean, some of them were really quite angry about it. It was a strange experience.

DS So you were just in this meeting with these people you didn't know?

DD A day and a half. And you didn't have to do anything, but one guy who was conducting the Madison Symphony—a position of some leadership—kept making moves to offer direction to the group, but people just didn't really want to go with him. At that point, I was saying to myself, "I'm kind of a young guy to offer to lead this business." And I learned something really, really important, and that is, you know, if you're in a group, you're not hidden from view, and if you're not trying to actively help—if I don't do enough, I'm going to have people even more mad at me than if I tried to do something and I fail, hands down. Wow! Karma? I don't know. But it was really spooky. And by the end of that year, when I began to stretch my wings a bit more, I was elected

People do want leadership and seize it.

President of the Medical Staff at Wisconsin. I kind of decided, "Well, I don't have anything to lose." I did have some things I wanted to see happen, and I think that is part of it. People see some of that, and they see that you actually have some ideas, and people do want leadership and seize it, particularly if the ideas are not nutty, and it seems like it's headed somewhere

on a train you'd like a ride on. And then I think, frankly, enthusiasm and energy are part of it too. Because, honestly, it isn't smarts. I'm absolutely convinced of that. You can't believe how far behind I am on a jillion things.

DS Yeah, but something else, though: I think when you talked about the willingness to meet with other people, it seems like you'll take the time to go and talk to some. I've seen you at this conference four or five times just talking to a couple of people, saying, "That'd be a good thing to do," and giving them encouragement.



Next-generation Boundary Waters Canoe Area (BWCA) trip in 2009, including Don (far left) as guide, great-nephew Austin, nephew Stuart, Stuart's cousin Scott, great-niece Angela, grandson Beau, and daughter Catherine LeBlanc. Don had taken his children to the BWCA a generation before.

Source: Personal collection of Don E. Delmer.

DD Well, I think you have to like people, and people need to think you like people. It's true! Let's face it, I'll tell you the scariest thing that happened to me in Utah, without a question: the animal rights people were going to try—and I don't know if you remember that—to stop the university from using dogs in research. And Rod Decker had a Sunday night program, half an hour long.

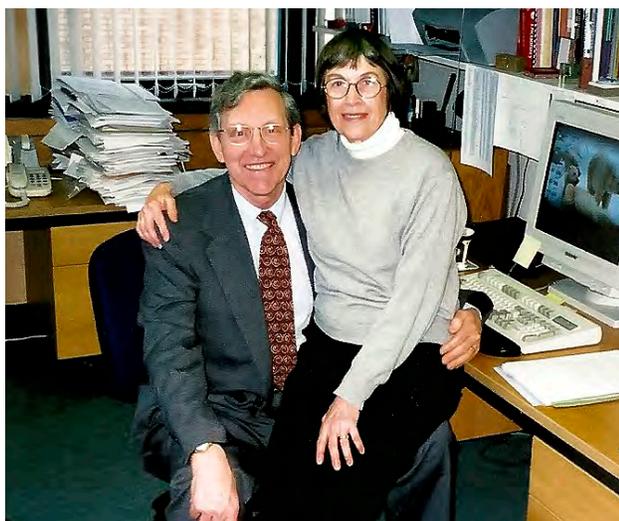
He'd get people on television to debate these issues. It was the Sunday night before the election two days later—the voting on this animals-in-research issue—and I went on the Ron Decker show. I had Jack Gallivan's son and some other key media consultants working pro bono with me at Utah, and those people really knew how to do

PR. The Salt Lake City crowd really know how to do that line of work. I mean, they really do, and they're very, very good at it. And they had me shined up for that program like you can't believe. They would actually take everything I said in the paper and on the radio or television, and once a month I'd meet with them and they'd give me a debriefing. "Oh, you were awful on that." And so we actually mocked out that whole interview, and some parts of it we ran through multiple times. By the time I got on that show—it was my content, they didn't tell me what to say—I was totally relaxed. The other person was very nervous and the lights were very bright and hot as well. But the scary thing was, we won the vote, we just blew them out of the water, actually. But the other thing that was really—yeah, preparation is part of anything—but the other thing that was really fascinating, this woman called in from Bountiful or Orem or wherever, the next day, and said to the Health Sciences Center Media Department, "I've always been against using animals for research, but as long as Dr. Detmer is Vice-President there, it's fine with me." I mean, that's Ronald Reagan stuff. I mean, it's really scary, actually. It was kind of terrifying. But I think, I don't know, I mean, you asked me this open kind of question, and all I can do is tell you the sort of weird things that have happened in my life. But they are truly speculation.

I will have to say I think the hardest thing I ever did in my life was going to Cambridge.

DS Really? Why was that so hard?

DD Totally new culture, 800-year-old university. Phenomenal scholarship but totally set in their ways.



Source: Personal collection of Don E. Detmer.

Mary Helen visits Don in his office at the Judge Business School, Cambridge, 2000.

Why not? It's worked well. But a new field—health management—in a new department—pure business school. It was like pushing a string.

DS Did you know that at the time?

DD Yeah, of course I did, and I was willing to take it on, but it was hard. You know, it was really hard.

JA In what way?

DS Could you explain why you wanted to go there.

DD Well, I was tired of running two academic health centers despite having loved both jobs while I did them. Interestingly enough, while it was a challenge, I did publish the Blue Ridge book, edited with Elaine Steen. It came out from Cambridge University Press last year.¹² So I don't think I had mentioned that that was another thing I started along the way. The Blue Ridge Academic Health Group is a think tank for academic health center leadership ideas. While Cambridge had its challenges, Mary Helen and I are really glad we went there. It was a growth experience in many ways, and we also had many, many pleasurable times. By the time I got past the third year, I kind of knew the territory and had established some friends. And of course Cambridge is such an unbelievable environment. So I'm very happy I did it.

DS I'm not exactly sure when you came back.

DD Christmas of two years ago.

DS So soon after that, they hired David Brailer.



Source: Personal collection of Don E. Detmer.

Clare Hall colleagues with Don when he received his Master of Arts degree at Cambridge University, 2001.

DD Yeah. Well, I got interviewed for Brailer’s job. [laughs]

DS *I was just going to say, “How come they didn’t pick you?”*

DD No, actually, I’m glad they didn’t. But it is a funny story, and I think, frankly, even if it had gone totally on the up-and up, I think Brailer would have gotten it, and I’m glad he did. But it is a funny story. Senator [Bill] Frist sponsored a retreat of health staffers to Vanderbilt—before Brailer was appointed—some months before that. And I didn’t even know that this post was kind of in the works since I’d been a bit out of touch being mostly in the UK, and Brailer and I were both there. It was the first time I had met him. He came up to me and he asked, “Do you have any interest in being named to this new job?” And I said, “Well, I haven’t heard much about it, but yeah, I’d be interested in being considered for it.” And he said, “Well, I heard your name as a person who might be [interested].” I had no idea that he was also somebody being considered. But I came away really impressed with the guy. We actually had a session together on NHII. Arrogantly, I was thinking either this guy has read all my stuff and agrees with it, or intuitively, he’s also come up with it himself. But either way, I don’t care, I really like the way the guy thinks. And so it was really a peculiar experience. So

I like situations where I have room to innovate and **play. I really see adult work, at its best, as play.**

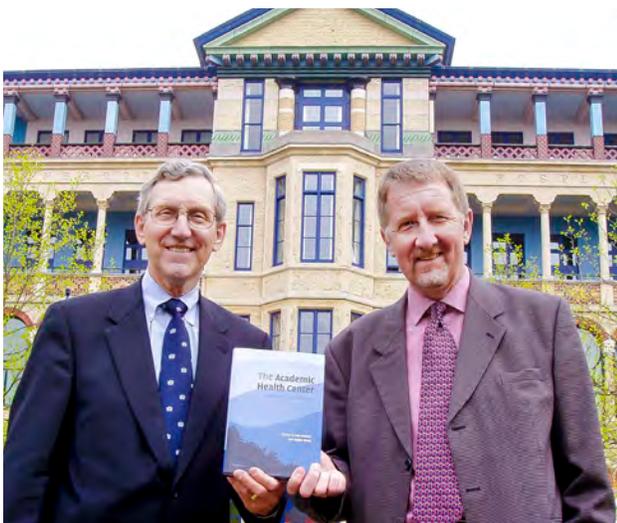
that was prologue. Well, some weeks later, I keynoted a European Union program on informed and involved patients, European-wide, in Cork, Ireland.

DS *You wrote a report about that, didn’t you?*

DD Yeah, I did. At any rate, the meeting was in Cork. And I had not ever taken some time when I visited Ireland to just absolutely totally get away—leave my computer behind and just escape in a car with some friends and explore the Ring of Kerry in Western Ireland. So after my talk, we went to Kinsale, stayed there a couple of days, and then went on our car trip. Well, three and a half days later, I finally go to a little Internet place in Kinsale and checked my e-mail, and Bill Yasnoff is after me to call him

ASAP.

Bill sent me [laughs] this e-mail that the Department and White House are trying to get in touch with me about the National Coordinator job. [laughter] And I look, and the message is five days old! “And if you’re interested, if you would please, call and say so soon.” Anyway, that was a really pretty strange kettle of fish. It was around three in the afternoon. So four in the afternoon in Ireland, I’m calling—which is morning over in Washington—I’m in a phone booth in Kinsale, Ireland, and [laughter] being interviewed by the White House and the Department. And I said, “Look, I realize I’m really late getting into this call



Source: Personal collection of Don E. Detmer.

Richard Barling, Director, Cambridge University Press, and Don in front of Cambridge’s Business School holding Don’s newly printed book, April 2005.



Source: Personal collection of Don E. Detmer.

Elias Zerhouni and Don Detmer at AMIA Plenary, October 2005.

due to my travels and being out of touch. Probably the water has gone right on past by now.” And they said, “Well, yes, things are really well along. But since you’re on the phone, would you be willing to actually talk about some of the issues as you see them?” So I first talked to someone in the Secretary’s office, and then they hooked me up with the White House, so that was my White House phone booth interview! I had this outrageous phone bill for using the phone booth in Kinsale. Anyway, I figured it was not going to come to anything, and it didn’t, because, like, two days later, they announced that Brailer was the man. So it was pretty funny. But, as I said, honestly—and this is not really in any way a sour grapes deal—I think I got the better job with AMIA, as it turned out! I really do. Because I like situations where I have room to innovate and play. I really see adult work, at its best, as play. And life is short enough, that if you can’t enjoy it, even when it’s hard work—

DS That’s a pretty serious job Brailer’s got.

DD Oh, it is! And not only that, it’s very constraining. Whereas with AMIA, I’m not saying it’s not constrained, I’m working with a board. Believe me, I know what working with boards is like. But I think on the other hand, it’s a situation where this board is saying, “Do something!” They’re already saying, “Do something!” And I have a penchant for doing things. So that seems a much better deal, whereas David Brailer was also being asked to do big things, but don’t spend money, dah-dah, dah-dah, dah-dah. Plus, I’ll have to admit, I think his knowledge of economics and those fields is a real plus. I think he’s done a very nice job. I heard somebody tell me this morning he resigned or something.

JA I heard that, too.



Source: Personal collection of Don E. Detmer.

Donald and Mary Lindberg and Don chat at a May 2005 tribute to C. Everett Koop, MD, pediatric surgeon, health activist and former U.S. Surgeon General. The event was sponsored by the Legacy Foundation, Mrs. Frank Perdue and the Friends of the National Library of Medicine (FNLN), and held in the U.S. Senate Caucus Room (located in the Russell Senate Office Building). Don Detmer also attended a February 2004 celebration of the launch of Dr. Koop’s papers on the National Library of Medicine’s “Profiles in Science” at <http://profiles.nlm.nih.gov/QQ>. The 2004 celebration was held in the Senate Hart Office Building and sponsored by the FNLN and the Legacy Foundation.

DD But I've also been hearing for some weeks, that was in the works, and also who was going to take his place.

DS *They haven't called me yet.*

DD Yeah! Well, they haven't called me, either, but I'm already occupied at AMIA at this point. With management jobs one always wishes that you had gotten more things done. I mean, just in terms of actually accomplishing something truly worthwhile.

JA *My question now is what would you regard as your biggest accomplishment? What are you most proud of?*

DD Ooo. [pause] You know, I'll take a risk of being misunderstood. You asked me what I thought I was most proud of. I probably spend too much time talking about the fish that got away than I do about the things that happen as I anticipated. Part of both farmer and cowboy cultures is not to get too "big for your britches," so it is uncomfortable for me to talk very long about myself.

When I was in junior high school, we had this time in one of my classes where we were supposed to pick out somebody in the class that someone wanted to say something about, and what they thought the person would do. And one of my classmates, a gal I also went to church with, commented about me. She saw me as worthwhile. "I don't know what'll happen with his life, but he'll do worthwhile work." [laughs] It's sort of a homely word, in a way. But I have to say, honestly, I guess my mentality has always been, "Well, does this look like it's worthwhile enough to

do, to even take on, or try to do?" So this idea that clinicians don't know enough about the management of healthcare organizations and quality of care, I'll start that. So I'm proud of what I've contributed to health systems policy and management. I'm happy that I was able to do that. Obviously, I'm happy that I did this National Health Information Infrastructure thinking, and it's going forward. But I'm also just white knuckled, wanting to make sure that that Global Trial Bank progresses or, if not, that clinical trial data make progress on an international scale, because I see that as hugely important. Is there a viable way for the world, transcending governments, to create structure that involves government, but also just the right kind of mix of personalities—because ultimately it comes down to people. Also, it comes down to souls that actually have enough stickiness in an organizational context, that new people stand up there and take their place when the time comes, so it is sustained, so you get continuity of movement over time. And I guess my point is that I'll be satisfied if someone sincerely says, "Well, that was worthwhile." [laughter] So clearly I do also play to an audience. My mother, when I was an infant, was very ill—she almost died, actually, after I was born, and she was pretty sick for a couple of years. I was taken care of by a maid, and I think perhaps as a result of that, I always had the tendency to want to get attention in a positive sort of way.

DS *From your mother?*

DD Well, sure, and also just from anybody. And so when I was in Lindsborg and I was going to Sunday school, I'd be the one that would be asked to stand up



Source: Personal collection of Don E. Deimer.

Fly fishing North Fork of the Madison River, Wyoming, timeless.



Source: Personal collection of Don E. Deimer.

Receiving Honorary Fellowship in the American Academy of Nursing (AAN) from President Joanne Disch, 2012.

in front of the congregation and recite the Beatitudes or something, and I could do it somehow—I just did it. But I think it was sort of an issue, also, in combination—I won't downplay the ego need side of this—but I think within the context of both ambition and visibility, there is this cowboy and farmer ethic in Kansas, "Don't get too big for your britches." So some visibility is fine, but too much can tend to make me giddy. That was hugely ingrained into me. And I'll have to admit, there would have been parts of Brailer's job I would have found very hard to do. There were even times when I was Vice-President for Health Sciences that, personally, I found very disquieting due to the attention it draws to you. Power can corrupt, and power does corrupt. If you don't have your feet clearly on the ground, you can become a real jerk. I think Will Rogers said it well: "It's great to be great, but it's greater to be human." And if you can pull off

being in positions of power and remain true to who you are, great, that's sort of the deal. So it's a long wordy response, and it's not an answer, it's just some comments.

JA I like that "worthwhile" part. We wanted to find out a little more about your involvement in professional organizations. We talked about the IOM, but you have done so much on the international scene, and we never did ask you why you did part of your college experience outside the United States. So let's start there, and then talk a little bit about your international involvement.

DD Sure. Some of that global interest probably has roots in being in this little town in Central Kansas where the King of Sweden came. Every year, they'd have a "Messiah" chorus, and the big singers would come in from New York and so forth, and



Source: Personal collection of Don E. Detmer.

Don (middle row, right) served on the Steering Committee of W.K. Kellogg International Health Leadership Program (KIHLP), 1984. The program was run out of Michigan State. The Steering Committee members (front row from left to right) are Gloria Smith, Hanmin Liu, Miles Hardie, and Roy Gerard (Director of the Program at Michigan State). Middle row from left is a Michigan State faculty education consultant, Carlos Leon from Columbia University, and Don Detmer. Back row from left is then-Dean of the Michigan State School of Medicine, Director of the Michigan State Campus International Center, Miles Hardie (Michigan State KIHLP faculty support staff), and Robert DeVries (Vice-President of the W.K. Kellogg Foundation).

some of them would be from Europe. There was an undercurrent of “there’s a big world” out there. And some folks would be going back and forth to Sweden. By the time I got to college, I really wanted to learn a second language well, really learn it. And so I was set up to go to Freiburg in the Black Forest for my junior year abroad. I’d taken two years of German, and this was going to be my chance. A week before leaving, the guy [in charge of the program] bailed out—Mannheim, I think was his last name, of all things, and he steamrolled me out of learning German. So instead, the opportunity came to go to Durham [England], so I went there. But I initially was really wanting to immerse myself in the culture and learn German, so I’d know another language, for crying out loud, because languages do not come easy to me. I have a nephew who speaks five languages unbelievably fluently, lives in Moscow, it’s amazing. Plus, as a child, my parents were at meals always reminding us of children somewhere who were starving. Anyway, I had a great time in college in England. Learning English! Upon reflection, I’m not certain of all the antecedent kinds of things that sort of played into my international interests. We did take two vacation trips by car to Canada and

I could have bought a new VW for the price of the PC and dot matrix printer.

Easy has nothing to do with most of the work one does that’s worthwhile.

later, Mexico. Perhaps that as well. And again, you get asked to do things. So I was asked to be on the steering committee of W.K. Kellogg Foundation’s international health fellows leadership program. That’s when I got my first RadioShack Trash 80, a TR 80, Model 100, after I had gotten an IBM desktop within the first year they’d come out. So I was determined to not miss the computer age. I thought it was going to be interesting. I even bought it new, still had the box, and all. The TR80 was great for trips to China, but the phone cup modem was only so-so. I could have bought a new VW for the price of the PC and dot-matrix printer. To her credit, Mary Helen never complained, despite our still paying off med school debts.

The point I guess I’m getting at is, I really enjoy these activities, and the invitations always led to fascinating experiences. There were 26 fellows from 19 countries. One year, we visited China, and another year China and India, and another year Oxford and London, and another year, Washington and Charlottesville. But at any rate, the time spent was really rewarding, and some of those people really blossomed. One former fellow is currently president of the China Medical Informatics Association, and another became Secretary of Health in Mexico. Later,



Source: Personal collection of Don E. Detmer.

"The Chas are a Hmong family we helped in the 1970s when they arrived from Laos. Catherine, Mary Helen and Emily sit among the Cha family. Boa Mary, named for Mary Helen, is on the far right."



Source: Personal collection of Don E. Detmer.

Mary Helen received a gift of Hmong needlework from the Cha family during a visit in 2006.

I was invited to join the China Medical Board, so I've been to China, I don't know, six or eight times, and Hong Kong and many other countries in that region of the world.

But, I'll have to admit, the tricky thing that's tough about the international challenge: it's not easy to accomplish something of lasting impact. At the international level, it is extremely hard to do. And so your point about The Wall Street Journal article is absolutely spot on. But I'm still convinced the world is now flat. And it was never easy, and it won't be easy, but easy has nothing to do with most of the work one does that's worthwhile. How easy something is to take on just doesn't have anything to do with most of what's worthwhile. It just doesn't! Tell me what's easy that's actually worthwhile—I mean, you know, something

may be fun to do as a diversion, but that doesn't give you much sense of accomplishment, right? Don't you think?!

There is a world out there, and **you're part of that world, and you're probably smart to know what's happening in it.**

DS Absolutely.

DD So anyway, I guess I do find it's satisfying to learn from other people's cultures and have them learn from yours and really find out that, hey, we really are clearly in this together. And that doesn't mean that we have the same values. Sometimes cultural clashes are really not easy; it can become pretty uncomfortable at times. And right now, of course, with the current Bush

administration, I can tell you the National Library of Medicine is seen in a few places in the world as being an arm of President Bush, it's not seen as the site of the wonderful things we notice and appreciate.



Source: Personal collection of Don E. Detmer.

Covey Carpenter, Don's niece's son, learns to catch sunfish from Don at Branch Point pond, 2003.

DS That's what some are saying about this Internet deal, is that the US government's controlling that.

DD Yeah, well, and they say, "Well, that's the challenge." And it's like trying to collaborate in anything: unless the other person is truly willing to give and even lose at times, you're not collaborating, you just aren't. Too many sit down with other folks just wishing to control it. And I think that's just what it is. And if you're really arrogant enough to think that you've got it all figured out and you are unwilling or unable to hitch yourself to another vision, a future vision, and know that some of your own dreams may not occur, but it's still worthwhile, I think then that's what it's all about.

Curiously, I'm not certain that had I grown up in Boston, international interests would have developed. And I'll tell you why. Out there in Kansas and Oklahoma, those old farmers knew what the price of corn was everywhere in the world, and what the current weather was like in Russia, and what was going on to affect their crop at market. And those people traveled. Those people traveled a lot. When they got into the winter months, they were off and roamin'—I mean, all over the place. And on the surface, it seems very paradoxical. All too often the coastal citizens may cast them as a bunch of rubes, but a lot of those critics—while putting down the Corn Belt, Bible Belt kind of mentality—have never seen the world and don't know



Jeff Williamson (taking the picture) and his daughter Isabel join Don on the ice for some hockey, January 2010.

Source: Personal collection of Don E. Deimer.

what's really going on. Forget it! A lot of the "flatlanders" are really pretty sharp. And so I think that was also a part of my philosophy, that there is a world out there, and you're part of that world, and you're probably smart to know what's happening in it.

You guys, I'm sure, are absolutely exhausted! You've been going through these things for hours and hours.

JA Oh, this is really exciting! Because the final question is the one about if you had advice to offer future informaticians, what would it be? That's always the final question.

DD Sure. Well, I have to admit, I mean, you get into the issue of advice, and you start to also reflect on your regrets. I, unfortunately, gave way too much of my early life to my professional development, and my family didn't get some things that I really wish they had. We had foster babies at one point, took them for five days until they got adopted out and so forth. We were just interested in trying to be helpful. But at times, I just wasn't all the parent I wish I had been because I was stretching myself too thin. Probably most people heading into informatics careers today [chuckles] have gotten those priorities a little better sorted out than I did in my time, because when I came along, I was 80 to a 100 hours a week in the hospital: Hopkins and Duke surgery training demanded it of you. Doesn't leave a lot of you left. So I'd have to say, if you



American Gothic, snowy version, 2011.

Source: Personal collection of Don E. Deimer.

can, balance your priorities a little better than I think I did.

I never really learned good parenting skills, and as a result, I'm not necessarily a great parent. I think I'm a better uncle or friend. No, I really mean it, because I need to detach a bit. With my kids, I'd get too anxious, I want to be too involved.

Whereas I think if it's just a kid, I can help them have fun and learn a few new things. So when kids come to our farm, man, I can give them the time of their life on horses and fishing and flying a kite. And if they don't want to, we can find something they do like and work on something else, paint some rocks or whatever. So I guess that's all not quite informatics. Happily, I have been blessed with a devoted and wonderful spouse, Mary Helen.

I think if we're looking at informatics per se, well, I guess I'll be speaking somewhat from my current hat

as president and CEO of AMIA, so it's not so much a Don Detmer view. This is more of an institutional response to that question. But I think it's now time for us to realize that if at some point, if you're gonna be an adult, then this emerging profession has come to enough age that it really needs to start really asserting

itself, as though it really is a formal discipline. And you need discipline in some respects, but all disciplines that emerge from the ooze are a little fuzzy at the margins and have some things about them that people get anguished about. But I think the point I'm making is that informatics is great. I'm

really passionate about informatics and what we're going to do with it. I think it really can help our world in a lot of unique ways. Getting the right synthesis of carbon and silicone relating to health is really, really important. And I guess I think that there are still people who see it simply as a serious avocation,

Don't worry too much about the failures, 'cause you're gonna have them.



Source: Personal collection of Don E. Detmer.

Don and his grandson Alex digesting the day's news, 2006.

but I think it's high time to see it as a profession. And I think it's time to do the things, then, that you must do in light of this in professional terms. And keep in mind, I didn't pass my surgical oral exams. So it's not like I've always been a winner in these ways of the world on the professional side.

Having said that, even struggling to try to pass the certification hurdles and such, I learned quite a bit. And I gather at some point—what I'm getting at—is, the system still accommodated me at the end of the day somehow. So I guess what I'm really saying is I think I get frustrated with people who either are too comfortable in the moment, let alone live in the past, for crying out loud. So my view is, look out there. Look out there and try to envision something and drive to it—drive to it. And be a party to others, who can see the promise that this can represent, and model that to young people, and bring these people along as future leaders. And don't worry too much about the failures, 'cause you're gonna have them, at particularly this stretch—you're just gonna. I mean, as I said, I still could tell you a bunch of other things I got into that didn't work out. So you see some of them that I lucked out on, but some of them, you don't see at all. But if the end is worthwhile and the means are honorable—that just isn't failure.

But anyway, I would say that I think it's time for us to really broaden and develop the discipline's full intellectual base. At some point, it's time to quit talking and try to do something that can,

in fact, help folks and really do it vigorously. And that means put your time and your body on the line and share, and buy-into other people's dreams. It's not like these visions are all developed. And then be willing to do your share of working on it.

I will have to say, I'm sounding like I'm complaining, but I'm not. One of my big questions, when I was negotiating with [Charlie] Safran and the Board about taking the AMIA post, was "Would I actually get mind share and shoulder share if I took the job?" So far, so good. So some of my advice is to take the field of informatics really seriously—I think it is a really worthy endeavor. It's really worthy work and a great way to spend one's life. But publish your findings. Do research and get it out there. And it is funny, once you get it down on paper

and out there in the world, it's really amazing, it's almost magic—spooky, spooky, how the printed word is powerful. It's like the book that you guys did.

DS I know.

Really carefully listening to their stories, really listening very carefully and finding out precisely where it hurt, how it hurt, when it hurt, what makes it better, what makes the symptoms worse.

DD And it comes back to you from all over the place, in ways you kind of never imagined.

DS That's great.

JA Is there anything we haven't asked you?

DD Well, actually, I was thinking of that—and I won't keep you all night—but a couple more things. You asked me some of the things I am proud of. One of the things was my clinical and research work in sports medicine, which really has been true



Cheshire Cat rock painting.

Source: Personal collection of Don E. Delmer.

research. I mean, I actually found out something new about the anatomy of the leg that hasn't been reported since Galen's time, about the anatomy and how it plays out in clinical disease of some athletes. The problem is not a life-threatening illness—it's a quality-of-life kind of issue, but relating to fascial compartment syndromes in the leg and media-tibial stress syndrome. Essentially, it creates sufficient pain that they cannot do their sport. Curiously, it's typically a disease of distance runners. And I kind of like to think that that's my own mindset. I'm not a sprinter. If you tie into something, you ought to tie into it for a time, because eventually you'll learn a lot and also wear your opposition down. Eventually, people just go with you 'cause you either win them over with your findings or they're tired of arguing at some point.

But anyway, the point is, I actually looked at a lot of these patients and just by really carefully listening to their stories, really listening very carefully and finding out precisely where it hurt, how it hurt, when it hurt, what makes it better, what makes the symptoms worse—and writing all that down, patient after patient

after patient. By doing this over a number of years, I was able to really make very basic contributions to the understanding of these diseases. For one condition, I even developed a new operation that worked well! At eight years post-op, 80% of the folks were cured, and 90% of them were substantially better. That's pretty good for an outpatient procedure under local anesthesia. It was both exciting and very satisfying to really understand, truly understand something that no one had ever understood before. And that's exciting—I mean, truly original research relating to a form of chronic periostalgia. It's just one cause of chronic pain of runners that they get on their medial shin. I literally figured out what was going on, and I figured out a way to diagnose it and figured out a way to fix it—soup to nuts! So that was pretty satisfying.

JA Worthwhile.

DD I started painting animals on rocks in '72, and people still tell me where in their house or office they



Source: Personal collection of Don E. Detmer.

Thanksgiving, 2009. Fabio, Emily, Bella, and Alex Ingrao; Don; Catherine and Beau LeBlanc; and Mary Helen.

have 'em. I need to paint you two a bear rock, just because you've heard me out on all of this life story.

Most of the time, it's a little bear, just a smiling bear, totally innocuous. There is always something to work on! Thank you for this interview and your patience.

DS Definitely. It's been wonderful.

JA Thank you so much. We really wanted to ask you, since we can't interview him, about Gene Stead.

DD I did interact with him when I was a resident at Duke. In fact, Bill's sister was a medical student on rotation with me when I was a house officer, and so Bill at that time was the kid brother, who I'd actually seen on a couple of occasions. But the father, Dr. Eugene "Gene" Stead, was Chief of Medicine, and at the same time, David Sabiston was Chief in Surgery. Gene Stead, like Sabiston, was already obviously a legend. He had been committed to the NLM, and so when I got down there for my surgical training, I wanted to go by and introduce myself to him. He was terrific: "Come right in, sit down." One of the things I was concerned about and very distressed by was some of the way patients died under my care when I was at Hopkins, and a little bit at NIH, but definitely at Hopkins. And I wanted to see if there would be some way that we could have a better dialogue with patients about how they chose to end their lives. And Dr. Stead had done a fair amount of writing and thinking about that. I had a draft proposal that I brought to him, to see if he thought that this would have any utility. It was an "end of life" consultation team that a doctor could request to visit the patient and family to solicit information and advice. The recommendations were like any consultation, meaning they didn't require action on the part of the clinician of record but they added valuable insights to guide a better care process

in such circumstances. Anyway, he was very gracious and took my proposal. I was very impressed. And I wasn't even one of his, quote, "boys." I was actually over on the other side of the "church," in Surgery. Again, the thing that was amazing about him is he remembered me even though I didn't see him all that much. I was only there at Duke about three years, and then I left. Keep in mind, he started the PA program. And when I was there, I started the surgical associate part of the PA program, so we also later had a connection that way. I was Co-Director of the PA program at one point, with Jim Nuckolls, who was Chief of Medicine when I was Chief Resident of Surgery. So I stayed a little bit in touch with him that way, and then over the years, when I was involved with the American Academy of Physicians' Assistants. Of course we'd bring him in periodically, every 10 or so years, to give some history and current assessment of the field. He was always very gracious, and did that wonderfully well. He was always seen by the residents as very tough. His famous quote, of course, was, "What this patient needs is a real doctor." But Sabiston was the same way. Those were different times, totally different times. You couldn't do it that way today. But on the other hand, I would say he was not a mean person, he was a strong person. He really wasn't mean just because he was tough. Although he obviously demanded a lot of folks, he'd also demand a huge amount of himself. You can see that same drive in Bill—just amazing drive, is just what it is. And I don't think it's ambition, I think it's drive. And that, I think, was one of the things that typified Gene Stead—drive combined with a desire to do honorable work. He really took to the fight.

JA Thank you.

DS Yeah, thanks.

[Published June 25, 2015; updated September 4, 2015]

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<http://lhncbc.nlm.nih.gov/project/medical-informatics-pioneers>

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