

Paul Quie, M.D.

Narrator

Dominique A. Tobbell, Ph.D.

Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

In 1970, the University of Minnesota's previously autonomous College of Pharmacy and School of Dentistry were reorganized, together with the Schools of Nursing, Medicine, and Public Health, and the University Hospitals, into a centrally organized and administered Academic Health Center (AHC). The university's College of Veterinary Medicine was also closely aligned with the AHC at this time, becoming formally incorporated into the AHC in 1985.

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 20th century. AHCs became not only the primary sites of health care education, but also critical sites of health sciences research and health care delivery.

The University of Minnesota's Academic Health Center Oral History Project preserves the personal stories of key individuals who were involved with the formation of the university's Academic Health Center, served in leadership roles, or have specific insights into the institution's history. By bringing together a representative group of figures in the history of the University of Minnesota's AHC, this project provides compelling documentation of recent developments in the history of American health care education, practice, and policy.

Biographical Sketch

Paul Quie was born in Dennison, MN on February 3, 1925. He received his BA from St. Olaf College in 1949 and his MD from Yale Medical School in 1953. He did his internship at Minneapolis General Hospital (1953-54) and his residency in Pediatrics at the University of Minnesota University Hospitals (1954). From 1955-57, he served as a medical officer in the US Navy. In 1957, he returned to the UMN as a research fellow and as Chief Resident in Pediatrics. He served on the faculty of the Department of Pediatrics from 1958, and was Chief of Staff at the University Hospitals from 1979 to 1984. From 1962-64, he was a guest investigator at the Rockefeller Institute in the laboratory of James G. Hirsch. He became the first director of the UMN Biomedical Ethics Center in 1985. He is currently Regents Professor Emeritus in the Department of Pediatrics.

Interview Abstract

Paul Quie begins by discussing his background, including his childhood, why he went into medicine, his education, and being drafted into the Navy. He discusses his experiences as a student at Yale Medical School, as an intern at the Minneapolis General Hospital, as a pediatrician in the Navy, and doing research at the Rockefeller Institute in New York in the early 1960s. He describes medical developments in the 1950s; the environment in the UMN Medical School in the 1950s; the American Legion professorship; his research; collaboration between Pediatrics, Medicine, and Surgery in the 1960s; the UMN Pediatrics Department; the College of Medical Sciences deans; the faculty practice issue and Robert Howard; leadership at the UMN health sciences; the strict full-time model in Pediatrics in the 1960s; the relationship between the UMN and private practitioners in Minneapolis and St. Paul; the effort to establish a second medical school in the Twin Cities; and the establishment of the Department of Family Practice at UMN. He also discusses medical specialization in the US; the establishment of the Children's Hospital; the medical school curriculum revisions in the 1960s; the reorganization of the health sciences in the 1960s; the Korea Project; the Program in Human Sexuality; the pediatric infectious diseases program at Red Lake at the Indian Reservation; the transsexuality program in the late 1960s and early 1970s; the appointment of Konald Prem as chair of the Department of Obstetrics and Gynecology in 1976; retrenchments in the early 1980s; the NIH; the early history of HIV/AIDS; the Center of Bioethics; and the Rural Physician Associate Program. He talks about Lewis Thomas; Irvine McQuarrie; John Anderson; Harold Diehl; Robert Howard; Neal Gault; Lyle French; John Westerman; Richard Chilgren; his brother, Al Quie; and Jack Verby.

Interview with Doctor Paul Quie

Interviewed by Dominique Tobbell, Oral Historian

**Interviewed for the Academic Health Center, University of Minnesota
Oral History Project**

**Interviewed at 510-A Diehl Hall
University of Minnesota Campus**

Interviewed on March 21, 2011

Paul Quie - PQ
Dominique Tobbell - DT

DT: This is Dominique Tobbell and I'm here with Doctor Paul Quie and my research assistant, Eli Vitulli. It is March 21, 2011. We are in my office at 510-A Diehl Hall.

Thank you, Doctor Quie, for joining us today.

PQ: You're welcome. This is good.

DT: I said this off the record, but I'll say it for the record. This is your second interview because you were interviewed in 1994 by Clarke Chambers, so I appreciate you coming back and talking some more about your experiences.

PQ: Okay.

DT: To start with, can you just tell me a little about where you were born and raised?

PQ: Yes. I was born on the 3rd of February 1925. I was the fourth of four children born on a dairy farm just eleven miles south of Northfield, Minnesota. My grandfather [Halvor Quie], I've always said, homesteaded, but I'm not positive about that. It was about 1856 when that land was obtained by the Quies. My grandfather emigrated from Norway with his family in 1845, I guess it was. They lived in Wisconsin for a while and then were on this land in Rice County, Minnesota, ever since. I felt like I was part of a long heritage there. When they ask if I'm a Minnesota, I certainly am.

[chuckles]

PQ: I don't see how I could be more of one, actually.

We were a family of six. My grandfather and grandmother had died by the time I was born, so I didn't know them. My mother's family lived on another farm in Goodhue County, not very far away. So that's where I grew up on that dairy farm.

DT: Did you do a lot of work on the farm as a kid growing up?

PQ: I did, yes. We got started right away. I think I started driving a tractor when I was about eight years old—it was the old McCormick Deering with iron wheels—and then driving the truck as a youngster, just on the farm. We were assigned chores very early on. I remember it as a fairly tranquil time, though. Things were pretty peaceful for us, during the early 1930s when I could start remembering. My recollections from those days are very positive.

DT: You don't have any recollections of being impacted by the Great Depression?

PQ: Very little. It's interesting. My father [Albert Knute Quie] was very frugal. He instilled in us that having a debt is probably one of the greater sins of commission. [laughter] We did not, so we were able to hunker down. It was probably terrible for country in terms of the economy, but wonderful for us. My mother [Nettie Marie Jacobson] was raised on a farm and all of us were farmers. I had two older sisters [Alice and Marjorie] who were able to be at Saint Olaf [College, Northfield] during those years. So we had a relatively easy time of it, from *my* perspective.

DT: What led you to start a career in medicine?

PQ: Well, that's a good question. I have to say this because it's true, that I'm always embarrassed when I read about other people who've done well in medicine because they wanted to since they were five years old, and, then, they dissected pigs and they did all kinds of things. But, for me, I was definitely on the pathway to be a farmer right through the middle years and high school. Then, it turned out that I learned somewhere along the way—my father never told me this—that he was preparing to be a doctor while he was a student at Saint Olaf. As I was growing up, it wasn't whether you went to college or not. It was when you would start at Saint Olaf. That was just an absolute normal pathway. [chuckles] So my two sisters were there.

But two things happened that I think are significant. This is sort of an answer to your question. I hope so anyway. My father, when I was a sophomore in high school, was what we called combining. It was a machine that harvested the oats and barley right from the stalk in the field instead of the old fashioned threshing machine. Dad was harvesting soybeans and, to make a long story short, his left arm, because of a tattered jacket and keeping the machine running, got caught in the cylinder and he lost his left arm. But he didn't die, and I always go into this anatomy. Because he had the presence of mind when he got his arm out of there, what was left of it, that there was something spurting with

each heart beat, so he grabbed the artery of his arm with his right hand. He knew it would be a minute or two of that kind of pumping, and he'd be dead. He walked then about a quarter of a mile to the neighbor's farm where he was harvesting for them. He never let go until he was in the operating room at the Faribault Hospital. I got called out of high school as a sophomore student and they said my father was in the hospital in Faribault. That weekend, my brother [Al] and me—my brother was a senior and I was a sophomore—grew up; became adults. We took over the responsibilities of farming and kept the farm going.

Then, a few months after that, the Japanese bombed Pearl Harbor. This was in 1941. I farmed full time with my father and my brother enlisted in the Navy and trained as a pilot. I farmed until 1946. There was no question that we go to college after all that. So I started at Saint Olaf then and lived on the farm with my brother. We still ran the farm during that first year at Saint Olaf. This is kind of amazing, I think. There was enough emphasis on getting educated. My brother had been in the Navy and flying, and in academic work and I had been farming, so not so much academic work. [chuckles] I came up here to the University of Minnesota for the summer session in 1946 and took English and math and just buckled down, got the rust off, and started at Saint Olaf that fall. Darned if I didn't get pretty good grades, which is still just a remarkable mystery to me how all that happened. I'm a very ordinary person. Everything about me is ordinary. But, somehow, that summer session...

I started Saint Olaf then in 1946 and had classes in the morning...my brother in the afternoon. So it was farming and Saint Olaf. Then the next year, the farm was rented then someone else put in the crops. I'm going on and on too much about this, I know. At any rate, I was able to make grades that were good enough so I applied for medical school and was accepted.

Why did I apply to medical school? I think it was just the challenge of the thing. I didn't have any deep desire to save people or anything like that. I had read *The Doctors Mayo* by Helen Clapesattle, University of Minnesota Press, 1941.

I think it's been reprinted. You would love that book, because it's Minnesota all the way. The Mayo brothers went to Michigan for medical school, then to Germany and Austria for more training, but it's all Minnesota, southern Minnesota. I think it had an influence on our family because the Mayo Clinic [in Rochester, Minnesota] was where we went for our medical care.

I applied to three places for medical school: Minnesota, Northwestern, and Yale. Yale, because my sister by that time was a medical missionary in the Cameroon in Africa and one of her colleagues was at Yale in medical school. So that sounded pretty good. I got a telegram that Professor [Levin] Waters was going to be in Minneapolis for a pathology conference, and could I "hold myself available" for an interview at the Curtis Hotel [in Minneapolis]. So I sent a telegram back, "Yes, I can do that." We had the interview in his room. Waters was a New Englander, kind of a taciturn guy and somehow was

intrigued by someone who had farmed that long. We spent a quite a bit of time talking about the science of farming. [chuckles] He was intrigued by the whole thing.

Then, two weeks later, I got my acceptance from Yale Medical School. My dad and I sat down and figured out how it would work if I went out there by train. The tuition at Yale Medical School was \$875 a year. At Minnesota, it was fifteen dollars a quarter or twenty dollars, something like that. Those days were so different.

DT: Yes.

PQ: Well, I farmed that summer and went out there by train in September and the rest is history. I just fell into an environment that was perfect for me, somehow.

I'll tell you just a little bit about Yale Medical School. I still have an enormous fondness for those years when suddenly, my horizons expanded beyond Rice County, Minnesota.

DT: [chuckles]

PQ: At Yale, we as students were colleagues of the faculty. It's something called the Yale System [of Medical Education]. It's a wonderful system. No exams. I think what Waters identified in me was that I was pretty much a self-starter or was able to plan my life, which is what it took at Yale. We were a class of fifty-two students.

I was able to get an internship at Minneapolis General Hospital at that time [1953-1954]. My life's expectation was that I would come back to Minnesota as a family physician. In those days, you either went into general practice or a specialty. That was the major choice. I didn't know what I would do, exactly. Minneapolis General was a competitive enough internship that I applied and was accepted. So then I came back and I've been a Minnesotan ever since.

As it said in the Spring 2011 issue of *Minnesota* magazine [published by the University of Minnesota Alumni Association], the first day of my internship in July 1953, Minneapolis was in the midst of a polio epidemic. During that first day in July, I did many spinal taps and patients were admitted to the hospital with polio.

Somehow I recognized during that first month or so that pediatrics was what I enjoyed. So I applied for a pediatric residency and was accepted and I started in July 1954 at the University of Minnesota—finally getting to what your interview is about. [chuckles] I started as a resident and was promptly drafted and appointed to the Navy and was asked to appear for duty at the Great Lakes Naval Hospital in Chicago in January 1955, which I did.

That's worth recording because I think it's one of the fairest things the military or the government has ever done. We were mobilizing for a war again. The Korean War was over, and they needed doctors so they drafted those doctors who were deferred for one reason or another during the Korean War.

In the Navy, I was assigned to Portsmouth, Virginia. The commandant of the Portsmouth Navy Hospital and the head of the Great Lakes medical scene were buddies. The commandant said, "Could you send a pediatrician down here?" I'd had six months by that time, six months of training. The head of Great Lakes said, "Well, we've got a guy here who has had a little bit of residency. He stayed back and helped with an exchange transfusion last night. If that would be all right, I'll send him down." So then myself, my wife [Betty], our little girl, Katie got in our car and drove to Virginia. I had two years, then, as a pediatrician in the Portsmouth Navy Hospital. That may not mean very much to you, but Portsmouth and Norfolk are very military. The Norfolk Training Base is still a huge Navy operation. I was involved with 6,000 newborns a year for two years, so 12,000 newborns that I'd been taking care of. Also, we were a referral hospital. I learned to be a pediatrician.

I came back here [the University of Minnesota] after that and became chief resident in pediatrics and on the academic track.

I immediately went into the laboratory of Lewis Wannamaker after finishing my pediatric residency. He and his group had won the Lasker Award for determining that the treatment for pharyngitis streptococcal disease with penicillin prevented rheumatic fever. It was a first rate laboratory. He came out here from Cleveland as a scientist. Before I was drafted he asked me if I would like to work with him after my residency. I said I'd try it for a year. So I came on board in his lab in 1958, became an instructor and faculty member.

So I've been on the faculty then since 1958, which makes it fifty-three years. [chuckles] That's the story.

DT: Yes, that's great.

You mentioned the polio epidemic. Do you feel that that had a role in you deciding to go into pediatrics, then, because you were seeing so many polio kids?

PQ: It may have. I think it might have happened even without the polio epidemic. But infectious diseases somehow got mixed up in that. While I was in the Navy, staphylococci became resistant to penicillin. So we were losing patients with staphylococcal diseases in spite of antibiotics. It was a combination of things. The Navy certainly confirmed I was a pediatrician all of a sudden. These things happened so suddenly. I grew up suddenly. I became a pediatrician kind of suddenly being responsible for those little patients in the Navy Hospital.

The science that was going on here [in Minnesota in pediatrics] at that time was phenomenal, as you've heard. Robert Good was in immunology. Wannamaker in infectious disease. And I was part of that milieu. C. Walton Lillehei in surgery. So, again, it's the scientific environment I think that made such a difference.

DT: In addition to everything that was going on in Minnesota, this was an exciting time within medicine in general. You mentioned penicillin. It had only been a few years since that was available, and then the other antibiotics and polio vaccine in the 1950s...

PQ: Yes.

DT: Can you say any more about that, about what it meant?

PQ: Polio was an interesting question. Jonas Salk's vaccine became available in the late 1950s, then the [Albert] Sabin vaccine. [Martins] da Silva was working with the Obstetrical Department at the University of Minnesota, studying the Sabin vaccine about that time. Liquid vaccine was put on a cube of sugar, and then the little kids, the babies would suck on the cube. It was a live attenuated vaccine that could be given orally. [Da Silva] began his study of oral vaccine when the Salk vaccine was being given to millions of people.

I use that as an example of how you can do things really fast and get the people behind you. Roosevelt, FDR [Franklin Delano Roosevelt] and Basil O'Connor, secretary of the [United States] Treasury did everything right. Lots of publicity, the March of Dimes, the whole thing, so total acceptance. There was a natural human rivalry between Salk and Sabin but it was a wonderful time.

DT: Of course, you had Sister [Elizabeth] Kenny here doing the rehabilitation work.

PQ: Sister Kenny right here, yes. A very dogmatic Australian. She was here doing rehabilitation. She was very powerful and very difficult to get along with, I guess. I didn't meet her during that time, though.

DT: You mentioned a little while ago about some of the great figures in Minnesota medicine from the 1950s. Can you elaborate more on what the environment was like in the Medical School in the 1950s?

PQ: Yes. There were giants walking around in those days in Medicine. That included Owen Wangensteen, of course. It's really so interesting what power they had and how little they realized it, and, yet, what a tremendous impact. The egos were not a big part of it. These were just people who were so good. Wangensteen grew up on a farm [in Becker County, Minnesota] and a Norwegian American, much like me, but I didn't know that, at the time. He, somehow, had the capacity for leadership that was remarkable. I'll put it in here right now that he was followed by [Doctor John] Najarian, who had equal or more capacity for leadership. His leadership was just really amazing. They were able to keep a whole department going and effectively.

In Pediatrics, at that time when I started, it was Lewis Thomas...*The Lives of a Cell* [: *Notes of a Biology Watcher*]. He left to go to NYU [New York University] and, then, became dean at Yale and, then, to Sloan-Kettering [Cancer Center]. Lewis Thomas had an effect also in his own way. The role modeling effect, I think, is so enormous. One of

my first social events was his going away party to go to New York. So I didn't get to know him well. But I was able to introduce him as the Culpepper lecturer out here some years later and, then, I also knew him in my research. So Lewis Thomas was a person who influenced me greatly.

Then, Robert Good was a genius who became a professor practically the year he graduated from Medical School. He had some time in New York at the Rockefeller [Institute] a few years before me and returned to Minnesota for a spectacular career in research.

Can I divert a little?

DT: Absolutely, yes.

PQ: Lewis Thomas was an internist, graduated from Harvard [University] in 1937. He got his training in internal medicine. He had been hired to be a neurologist at Tulane [University] in New Orleans. Have you heard this story?

DT: No.

PQ: He was recruited to Minnesota as the first [Minnesota] American Legion and Auxiliary [Heart] Research [Foundation] Professor. To this day, Minnesota is the only state where the American Legion organization has financed a professorship. The Legion's auxiliary raised the money in 1949 and 1950. These are people who had come back from World War II. Larry [Lawrence] Richdorf, was a pediatrician, Carl Platou, whose name you know, his uncle Erling [S. Platou], also a pediatrician, were leaders. Rheumatic fever was still a huge problem and the American Legion—in their minutes, you'll find it all—wanted the Legion to be known as supporting medical research for children. They didn't want them to be thought of as just selfishly taking care of the veterans. This was sort of the human leadership that prevailed. So they were able to raise a half a million dollars and start the American Legion professorship for pediatrics. Lewis Thomas was the first American Legion professor and, then, Bob Good as a young person was named the second American Legion professor and I was the third American Legion professor, appointed when Bob Good went to Sloan-Kettering in New York. I became the third American Legion professor after those two giants as predecessors. [chuckles] Well, I really had to buckle down and get to work. We now had a strong American Legion presence here. You'd think that every other state in the Union would have an American Legion professorship. Yet we're the only one. We have two Legion Professorships. The other is in the neurosciences at the V.A. [Veterans Association, Brain Sciences Center Chair], [Apostolos P. Georgopoulos].

DT: The fact that Minnesota is the only place with American Legion professors and the fact that it's because of the people who were here who attracted that kind of attention and that kind of research money being put here is a testament.

PQ: Yes. It reminds me of this little saying by [Johann Wolfgang von] Goethe—I have a lot of these; I call them my Chinese cookie sayings: “It’s not enough to think; you have to *do*.” [“Knowing is not enough, we must apply. Willing is not enough, we must *do*.”] Somehow, in Minnesota, we do! There’s a climate here, I swear, that is conducive to being able to being able to do. Like Bob Good was able to *do* all that stuff. Lewis Thomas was here and could get something started that was permanent. To this day, the American Legion is a coveted professorship. So there’s something different about Minnesota that I can’t put my finger on, but I think it has to do with a word that’s overused, which is kind of a freedom. We haven’t mentioned John Anderson, yet, or Irvine McQuarrie, but I had the sense here that once you have the trust of a person in these leadership positions you were free, be it Wangenstein or Najarian... McQuarrie was head of Pediatrics when I started and John Anderson... Those are the ones I can talk about since I was personally responsible to them. My own energy was my only barrier. Then it was a matter of getting along with colleagues and being able to do what needed to be done.

I was also able to be supported by a Research Career Development Award from the National Institutes of Health. I was given a John and Mary R. Markle Scholarship. Both my early mentors had studied at the Rockefeller Institute in New York: that’s Bob Good and Lewis Wannamaker. So in 1962, my wife Betty with the two kids and a station wagon, we went out to Rockefeller in New York for a couple years. How in the world it happened, I don’t know. It was not a very tough decision. It was just Minnesota and that’s what one did. Seize the opportunity!

DT: They supported their professors going out doing research elsewhere and, then, coming back.

PQ: And then coming back, yes.

I was Doctor Wannamaker’s first research fellow in his laboratory. Elia [M.] Ayoub was his second. Elia came here from the American University in Beirut in Lebanon and stayed on. He and I became scientific brothers. I stayed in Minnesota of course and Elia continued an outstanding career at the University of Florida in Gainesville.

Betty and I lived in New York and our fourth child was born in New York. I was known as the Minnesotan with the big family. Four kids was a big family already in those days, but it was the normal family at that time. I had a wonderful experience in New York. The Rockefeller had the same climate as the Yale Medical School in that the faculty there would help you, but it’s up to you. Rockefeller has that attitude in spades! I worked in the laboratory with James Hirsch and became a capable microbiologist and immunologist as well as pediatrician.

My own personal debt to the University of Minnesota is for the freedom to be able to graze in these wonderful scientific pastures that were available in those days. Can you imagine it? I can hardly imagine that everything was possible or so it seemed.

DT: It sounds incredible.

PQ: It was incredible, that climate of discovery.

DT: What was your research focused on when you were at the Rockefeller?

PQ: The first research I did in New York... In the early 1960s, the United States Department of Defense realized that infectious diseases accounted for more deaths than bullets in every war. They realized it and so they appointed the Armed Forces Epidemiology Board. There's a whole book, a history of that [*The Armed Forces Epidemiology Board: It's First Fifty Years* by Theodore E. Woodward, M.D.]. The Streptococcal and Staphylococcal Commission supported the research that I was involved in. Lewis Thomas was very active, as well as Lewis Wannamaker. Thomas was Yale and Wannamaker in Minnesota, and I was a young novitiate. We talked about white cells, and neutrophils in some of our meetings. I could work with these cells because they're readily available. You can just draw blood and have human neutrophils in abundance to work with.

The magic of American medicine during the 1960s and 1970s was clinical research. I think Europeans shifted to research institutes and the research and clinical side were done in different buildings. In America, clinicians were able to conduct research and have offices in the hospital.

Jim [James] Shannon started the NIH [National Institutes of Health] and *insisted* that universities be included in the research that was going on in the United States. We in Minnesota, with all our freedom, were right there with our hands open. I was familiar with that. My dad, a solid Republican, always accepted the farm programs of FDR.

DT: [chuckles]

DT: We often hear about the surgeons, the cardiac surgeons particularly, and what they were doing, but it wasn't just surgery. There was so much else going on as your work makes clear.

PQ: So much else was going on. Yes.

Another guy you probably have interviewed...Jim White, who is a world authority on platelets, the smallest blood cells.

DT: No, I haven't.

PQ: I studied the neutrophils. He studied the platelets. They're the cells that make the blood clot. He's a really interesting guy and contributed so much to understanding these platelets. I ended up having a neutrophil reputation, so I was invited to speak *all* over about the neutrophils.

DT: [chuckles]

PQ: I have a slide of Lewis Thomas' that reads: If you're interested in cells, pick the neutrophils. They're the most intelligent, most intriguing, most this and that and the other thing. [laughter] It is true. They're so remarkable. In one of my publications, I call them the "hard hats." In another one I describe them as the "marines" of our bodies. They don't replicate but they're there to be "first responders." The lymphocytes, which almost everybody in immunology study, are the "thinking cells."

[laughter]

DT: It's always great when scientists anthropomorphize their objects.

PQ: I know it.

DT: There's a lot of that. It's useful; those analogies are really useful.

PQ: Yes, I agree.

I was just reading David Brooks' new book last night...*The Social Animal* [: *the Hidden Sources of Love, Character, and Achievement*]. He claims that if you just have a name, George for example, that influences. That seems a little farfetched to me, however, these little influences lead you one way or the other...

DT: When you were at Rockefeller, did you ever think about not returning to Minnesota, either staying there or going somewhere else?

PQ: No. No. No, I didn't. It was strictly to come back to Minnesota, because we had deep, deep roots. My own roots are as deep as they come and my wife's family are Macalester [College] people. Her dad [Kenneth Holmes] was head of the history department there. My grandparents came to Minnesota in the 1850s. We had the four kids. No, there were no doubts about coming back to Minnesota. The family ties probably as much as anything.

This is going to sound like bragging, but during my career in Minnesota I was offered many heads of departments of pediatrics, our chairman John Anderson used to call me "Boomerang Quie." He'd send me out, but I always came back.

[laughter]

DT: It must have made some nice family rivalry, Saint Olaf versus Macalester.

PQ: Yes. It was good.

[chuckles]

DT: You mentioned a little while ago about people like Lillehei, also Richard Varco, and the great changes in cardiac surgery and, then, in the 1960s, the transplant surgery. What impact did that have on pediatricians? That must have increased the work load that the Pediatrics Department was dealing with because of that expanded surgery.

PQ: Yes. You could put it that way. The other thing is that we delivered those patients to the surgeons. There was a remarkable synergy between Pediatrics and Medicine and Surgery, especially in terms of the kidney. I say this facetiously, but they should have built the new hospital in the shape of a kidney. That's what was going on here. We had wonderful work going on with Al [Alfred] Michael and Mike Mauer in pediatrics. Al was a strong pioneer in understanding the physiology of the human kidney. Before him, Robert Vernier, now in California, was a wonderful leader and now, Mike Mauer, kind of a genius, strong teacher. Pediatrics had *great* strength. That's one thing that I really wish that I could convince you of. That's kind of my propaganda, but I think it's true that Minnesota was an unusual place with Pediatrics as strong, if not stronger, than Medicine. Oftentimes, in pediatrics, we are little people and do not have quite the same prestige as medicine. Surgeons also appreciated that; pediatric cardiology was strong and nephrology. The head of Medicine, Tom Ferris, was also interested in nephrology so that it was very strong in the Medicine department. Lou [Louis] Tobian discovered how the kidney regulates blood pressure, as another example of Minnesota's strength in kidney research.

DT: Talking about the strength of Pediatrics, you mentioned Irvine McQuarrie and then John Anderson. Can you talk about what their leadership was like and kind of the role that they played in Pediatrics?

PQ: Yes, I'll try. Irvine McQuarrie was able to convince Lewis Thomas to come to Minnesota. He was a leader in national pediatrics. He was quite old when I came on the faculty in 1958. However, during my internship and early residency before going in the Navy, I knew him a little bit. He was just a wonderful man.

Then John Anderson was his successor as chairman of the department. He had worked as a young man with McQuarrie. John was chairman at Stanford [University] but came back to Minnesota. I didn't know him as a Stanford transplant but as a real Minnesotan. He and his wife were very down to earth and believed Minnesota was the place for training academicians, just as McQuarrie believed. McQuarrie used the word that we were a "teacher's college." Minnesota is remarkable in that sense. We've always had a strong record of training practitioners, but, also, extremely strong science. John [Anderson] had a unique permissiveness that I suppose McQuarrie had, but I didn't experience. This is sort of personal, but my own marriage in August will be sixty years. Betty and I believe the strongest weapon in our successful marriage was trust. It's true. That's how John Anderson ran the Department of Pediatrics for the twenty-four, with trust. He trusted. He had confidence in us.

DT: What role did the deans then play in that context with Harold Diehl and then Bob Howard? Did they similarly trust the department heads to run things or did the deans have more of an involved role, would you say?

PQ: The role of the deans was different. It was kind of the way they came across to people. Their leadership was subtle in a way. Dean Diehl—you mentioned Diehl—was dean when I started. He was sort of hands off, but allowed people to grow.

Diehl was not a presence for me, personally.

Then came Bob Howard, who tried to be more of a manager. Organizations when they get as big as we were need a manager, I suppose. You need someone who knows what's going on. Bob Howard attempted to develop a structure and more organization of the faculty. He was one of our favorite assistant professors in hematology in medicine. A nice guy, funny and a colleague. Then he became dean and, all of a sudden, there was a different chemistry. It wasn't a particularly successful deanship. I still see him at the airport once in a while, a wonderful guy again. He reverted right back to being the guy he was before being dean...I don't know how long he was dean.

DT: Twelve years.

PQ: Twelve years. That's pretty long.

DT: Then Neal Gault.

PQ: It was Neal Gault who brought us back to the Dean Diehl type. He was very warm, very personable, never polarized or took sides. He listened. For example, when my daughter was hurt, he and his wife came over with a pie. He was that type of human person. One of his neighbors had him over for dinner a lot after Neal's wife [Doctor Sarah Gault] died and this is telling I think. After ten years we never knew whether he was a Republican or a Democrat. Can you imagine? I'm a flaming Democrat and people know it within thirty minutes.

DT: [laughter]

PQ: With Neal, you never knew. That's a gift. I suppose a dean needs that.

Then, he was followed by a colleague of mine in Pediatrics, David Brown. David was a very smart guy, kept things going, but he was more in the Bob Howard type.

Then we had an interim dean, Shelley Chou, who was just one of the sweetest guys. He always did his homework. He was one of these perfect people, you know, a neurosurgeon.

DT: I interviewed Bob Howard a couple of years ago now. You pointed out that he was pretty young, pretty junior when he was appointed dean.

PQ: Yes.

DT: I wonder how it might be perceived by the faculty that you had this young assistant professor. He may have been an associate by the time he was appointed, but he was young, and, then, he was dean overseeing these big powerhouses, like Wangenstein, C.J. Watson, and John Anderson. Do you think that that may have influenced the way his tenure went?

PQ: Yes, I think so. Then, there was one layer down: Lyle French, Richard Varco, Don Hastings, Gene Getgudas, and Ellis Benson. There was a whole layer of strong people plus the superstars. They were pretty much out to pasture by that time.

DT: My understanding is that Bob Howard tried to change the faculty practice policies.

PQ: Yes.

DT: And that raised the ire...

PQ: That's just like trying to rein back Social Security. It's the third rail phenomenon that you don't touch, unless you've got *exceptional* abilities in diplomacy. Diplomacy sounds a little cooked up, but there's something natural about a person who is able to lead, I think. Neal Gault had that.

Another person who came flying through our firmament was Art [Arthur] Caplan. I was the original person trying to get the bioethics center started. It was hard work for me. Then, Art came and that was the best thing I did in ethics, being able to attract Art to come out to Minnesota. He just took over here like John Najarian did in surgery. Caplan was a wonderful leader of the ethics program here, and you never knew where he stood actually, which was wonderful, because most things in ethics don't have answers. There are wonderful questions and talent for stimulating common sense discussion.

I don't really think it was his youth with Bob Howard. It might have been. But I think that the practice... There's no more tender part of the anatomy than a person's pocketbook, and Bob Howard tried to have a fairer system. He had about as much luck with that as [President Barack] Obama is having on the national scene now.

DT: I saw in the archival material that he was trying to institute this strict full time system where you contribute a certain amount to the department and Pediatrics was one of the only departments that actually adopted that system by the end of the 1960s. Do you recall that?

PQ: I do.

DT: How did your colleagues in Pediatrics feel about that, and why did you adopt this strict full time model?

PQ: I can tell you. John Anderson appointed me and another person, Mark Nesbitt to discuss and give him a report if we believed the pediatrics department would be better off with a central financial system instead of individual entrepreneurs collecting their own practice fees. We prepared a report and I don't know if it ever went beyond the circular file that Doctor Anderson kept for his reports. He was very cordial, thanked us for all our report and the next week at the faculty meeting, Doctor Anderson pronounced that the Department of Pediatrics is going to name a central financial system. No fanfare. Nothing at all.

DT: [chuckles]

PQ: That was gradually accepted. We realized that he knew something we didn't know. Everyone was soon happy with the new system. We didn't argue, and he knew we wouldn't. Off it went. I mean, that's how it happened. That's how Pediatrics led the way in the medical school. Dr. Anderson knew what he wanted and what was best for the department.

Al Michael was head of Pediatrics and then became dean. Like Doctor Anderson, he knew what should be done. He was always three jumps ahead of us and would let us struggle away with the first jump. That's the way things get done in this kind of a freedom/trust milieu, I think. I can't explain it. It's a subtle human behavior leadership quality, I guess.

DT: So it wasn't that John Anderson had a particular allegiance to Bob Howard or anything? It was just the fact that John Anderson thought this was the way to do it?

PQ: Yes. Yes. Yes.

DT: Did it change? Did you notice the effect in your pocketbooks or in your practice?

PQ: Yes. It was so much better and there was so much more money than we ever knew existed. It was just dramatic how necessary it was to have that business kind of an operation. It was *hugely* different and *hugely* better. Yes, I think everyone was happy.

DT: That's funny, because I got the sense from reading a lot of the debates over Bob Howard's efforts to change the faculty practice issue that one of the concerns had been, well, it's going to cut back on our money. It's going to limit our autonomy, so we don't want it. Yet, your experience is actually that it was better.

PQ: Better, yes. Yes. It was very complex... They had this grandmaster or something like that. I've forgotten what they called him.

DT: Yes, that was in the 1970s.

PQ: A respected downtown lawyer.

DT: It seemed that Bob Howard had tried to change the faculty practice issue and hadn't succeeded. Every few years it resurfaced, I think increasingly from Central Administration.

PQ: Yes.

DT: Then, you had this... I've forgotten what the name...

PQ: We'd get this nice letter from the downtown lawyer on very expensive paper each year and we'd put it in our files.

[chuckles]

DT: One of the things that Bob Howard told me, though, was the impetus for his efforts to change faculty practice actually came from the President. The President had asked him to look into the faculty practice issue. Then, subsequently, when the department heads opposed it, the President stuck his head back in and said, "Okay, this is not something that I want." It had always been a Central Administration thing, but Howard hadn't had the support of the President beyond.

PQ: Oh, I see. Yes. Was that Met [O. Meredith] Wilson?

DT: Initially, it was President James L. Morrill who made the request, but President Wilson repeated the request when he came to office.

You mentioned how great Minnesota was for training academic physicians and, obviously, the amount of research that came out of it and the clinical advances. Did you see that having an influence on the non-academic community, the private practitioners in Minneapolis and Saint Paul?

PQ: Yes, I watched it change from a family good feeling to more competitiveness gradually during my career here. I feel somewhat responsible for it myself because I slipped into the contentment that we were pretty hot stuff, and I didn't pay attention to the town/gown. I think I should have had my wits about me and understood what I understand now about human behavior and human nature. If I'd read David Brooks' book, I would have done better.

DT: [chuckles]

PQ: It happened. It definitely happened. I can't lay blame. It's just kind of neglect, I would say. Doctor Anderson didn't go that way. There was a trust that he had with us. I'm not sure he had the same trust in people outside the university. We became competitive.

DT: It seems that the frustrations of the private practitioners led to efforts by a group of Saint Paul physicians to establish a second medical school and have it establish in Saint Paul. Do you have any recollection of that effort to get the second medical school?

PQ: Yes, I do but not enough to discuss. It never got very far. The person leading it was a surgeon, Davitt Felder. Then, [the University of Minnesota-] Duluth medical school was established [in 1972]. There was a different motivation behind that. That was more to get the people in family practice.

DT: Another aspect of the town/gown tension seemed to be that the Minnesota Academy of General Practice led, at least initially, but Herb Huffington, were angry with or seemed frustrated with the Medical School that there wasn't a department of family practice.

PQ: Yes.

DT: They had a big role in getting the Family Practice Department established here. Do you have any perspective on that?

PQ: Well, I do, a little bit. In order to get it done, they assigned an internal medicine faculty member, Ben [Benjamin] Fuller. Ben Fuller was able to be thick skinned enough to handle the slings and arrows on both sides. He was fairly effective, I think. He wasn't in that position for very long. He was a necessary person to bring us to that evolution of this obvious need.

I've often thought that the way the United States handled this was so different from England and the other places I knew... The climate in the United States in 1953 was already to specialty.

DT: Pediatrics is interesting because, especially nowadays, it's considered primary care, unless you subspecialize within pediatrics.

PQ: Yes. It got to be primary care, but medicine is in there and family practice is there. We're all kind of specialists together.

DT: Specialists in primary care. [chuckles]

PQ: Exactly. Primary care is the umbrella and, then within that, everyone in primary care is a specialist. It makes it very expensive. That's kind of how we handled it, which is quite different from Europe.

DT: Yes, very much so.

The other effort that was spearheaded by private practitioners was an attempt to get the children's hospital established in the 1960s?

PQ: Yes.

DT: Can you talk a little about that and what your experience of that was?

PQ: The children's hospital came about, I think, because of the sense that we were insular and not as attuned to what was needed in the community. Al Michael and I would meet with the people that were planning this. Al and I, we commiserated with each other, "What shall we do?" We could feel it. It was going to happen. Then, they got the big heavy donors and they got it going.

We had a new chairman in Pediatrics, Bill [William] Krivitt, and Bill was a typical pediatrician with a heart as big as all outdoors and the kindest person and all. But, he was a competitor, and he fit the competitive mold. Then, we were very competitive. Infectious Diseases and several of the other pediatric subspecialties got along well.

DT: So was the competitiveness over referrals and, basically, how many patients you would be seeing? Was it that kind of competition or was it about more than just kind of who is getting the patients?

PQ: It was more ego, and subtle. I was so busy in what I was involved with during those years I wasn't aware of the swirls going on around me. I know the cardiologists got into some real fights. There were some real personality issues there. We could have done much better if we'd worked at it but we were in our silos. That was the subtle thing that was happening.

I talked about NIH and why the U.S. was able to have this wonderful clinical research and getting things done. If you took the editions of *Cecil [Textbook of Medicine]* from when I graduated in the 1950s until the latest edition, every disease that's in the index, you find the evolution of improved care and improved knowledge and improved treatment. It's dramatic!

Infectious Diseases was supported by the [National] Institute of Allergy and Infectious Diseases. Our loyalties in the laboratory were to that institute and the department became second. I think that was the *biggest* change for me. By the time I went to the Rockefeller Institute supported by a Career Development Award from the NIH and John and Mary R. Markle Scholarship, Minnesota's price was having me as tremendously loyal to the NIH that was supporting me and my infectious disease colleagues. This was happening all over academic medicine. I think that may have been the most significant undercurrent unseen force going on, more so than money from patient care. At Minnesota, we got into the maelstrom of selling the hospital. I think the fundamental spiritual change was our loyalty to something outside the academy, if you will. Now I realize one's loyalties are strong when your work is supported financially.

DT: To do your research, you rely on federal funds from the NIH. So are you saying that you felt the research you pursued, the research questions you addressed, that they were shaped by the fact that you wanted to satisfy the patron; i.e. the NIH.

PQ: Yes, but discovery is also a strong motivator. You're driven by your own publications and you're getting support for your laboratory and your reputation. It's just a *dramatic* way to make a living. Lewis Thomas writes about it, how he can tell when some major discovery has occurred in the laboratory because everybody is talking to each other in the corridors and everybody is walking about an inch off the floor with a big smile.

DT: [chuckles]

PQ: You only have this happen about two or three times in your whole damn career, but there's nothing like it. My own sense is I was so happy I was able to do that money wasn't a big part of the equation. I *knew* the cardiologists were making a ton more money, but I had the freedom to do what I liked to do. Ah! I mean it was dramatic! The NIH, you think of it as a bureaucracy and bureaucratic people, because they're sitting there in Washington. I enjoyed the people I worked with at the NIH.

But it's *you* that they're interested in. Their satisfaction is having you supported. The bureaucrats, so to speak, were the ones who were making my life so good! [chuckles] I'm exaggerating a little bit, I think. There were probably some bad apples and some lazy people, short-timers, and the rest there, too. But they did not cross my path.

DT: How do you feel that you and your colleagues balanced your functions as researchers, clinicians, and teachers? How were you and your colleagues able to strike that balance?

PQ: I don't know but it's a very important balance. Tremendously important and often done by a woman with a couple of kids in addition. We had it easy. Martha Yow wrote that book [*Balancing Act: Memoir of a Southern Woman Doctor*]. She was head of Infectious Diseases in Houston at Baylor [University] and, also, was editor of the *Journal of Infectious Diseases*, not the *Pediatric Journal [of Infectious Diseases]*. She's a pediatrician. She was married to [sounds like Eller D.] Yow, who was a Minnesotan, so she was up here for a while. She wrote this wonderful book on striking a balance. Y-o-w is her last name. It is very, very difficult, I think.

William Osler talked about compartmentalizing your life. The way this thing is written in the *Minnesotan*, it sounds like I'm a world beater, but, you know, I had fifty-eight years to do it, so it's compartmentalized, so I can do a whole ton of stuff. It was done sometimes with emphasis on the lab and sometimes in the clinic. I just a clinic half a day a week for all the immuno-comprised patients that I saw. Then we made rounds only three months a year, so it was very flexible.

The town/gown thing got too low a priority there. It's very important.

DT: I was going to ask—I know town/gown probably is a national phenomenon—whether you saw those relations as particularly potent, say, in the Twin Cities versus elsewhere.

PQ: I don't know. Dermatology is the one that *doesn't* have it—never has had it. It's a family now as it was when I was beginning. We were a family like Dermatology. We had our grand rounds with many physicians from practice... We had chief's rounds and Dr. Erling and Dr. Platou would always attend. It was really a cordial atmosphere. I think it may work better now with the new hospital [University of Minnesota Amplatz Children's Hospital].

DT: Yes, it will be interesting to see.

PQ: That will be really interesting.

DT: [laughter] That's for the historian ten, twenty years from now.

PQ: Yes, somebody will be sitting here and telling us what we should have done.

[chuckles]

DT: One of the big changes in the Medical School, it seems in the 1960s, more generally speaking, was the major revision of the medical curriculum. Were you involved in any of those curriculum revisions?

PQ: Yes, all of them. They cycle in every medical school in the U.S. That's just part of the beast. A new curriculum about every ten years.

DT: Do you recall what the incentive was for revising the curriculum in the 1960s?

PQ: Well, it was just the cycle that reached that place, as far as I'm concerned.

DT: The other big thing for the 1960s then was the reorganization of the health sciences and the dismantling of the College of Medical Sciences. When the College of Medical Sciences was in existence, which was basically all the way through up until 1970, did you encounter much interaction with, say, the Nursing School or Public Health or Pharmacy, at that time?

PQ: No, not really.

The interesting association we had was our Korea Project. This was in about 1954. The Korean War was over. I think it was the government U.S.A.I.D [United States Agency for International Development] that wanted to do a Marshall Plan for Korea, because their medical school at Seoul was devastated by the war. So they put out bids and support was obtained by Gaylord Anderson, the first dean of the School of Public Health. Pediatrics and the School of Public Health were together on that project. The history of that project is wonderful. That's all written up by Neal Gault. [Dr. Quie is referring to the article, "Korea: a New Venture in International Medical Education" by Neal Gault] All that information is there. That's my involvement with it.

But that Korean Project... I think we should mention. That's a jewel in the crown of the Medical School, School of Nursing, and School of Public Health (between 1954 and 1961).

DT: In the interview that I think Ann Pflaum did with Neal Gault, he talks about the Korea Project and there's a lot of material in the archives. It's fascinating that Minnesota was the center for that.

PQ: It's almost biblical. Tae Kim, one of our Korean American physician colleagues and a radiotherapist, came back from Korea telling us this story just a few months ago. Seoul, Korea now is the shining light in terms of the scientific programs. He informed us that Laos is developing a new medical school and the faculty at Seoul National University in South Korea *remembered* how Minnesotans came and spent months with them. They now are following the Minnesota example and sending their faculty to help Laos get their new medical school started. I think it's one of the best stories ever, that they're using the Minnesota model to help Laos get a new medical school going.

DT: What's your memory of the reorganization of the health sciences and the creation of the Academic Health Center? Do you recall what the impetus was for that?

PQ: I don't remember why it happened then. I have a feeling that it was because it was being done everywhere, I guess. I have no idea what the ideology was, what the *infecting* agent was.

[laughter]

PQ: But it happened. It was done in a very orderly fashion.

Lyle French organized all these new buildings, the Phillips Wangenstein and all that. He was then vice president for the health sciences and a nature leader. George Zuidema, head of surgery at Johns Hopkins [University School of Medicine] at the time...[from] Holland, Michigan was one of the visitors who reviewed the new program.

DT: I think Ann Pflaum may have interviewed him or maybe it was Clarke Chambers at some point. Yes, he seems to be a very instrumental figure.

PQ: Yes, yes. That history of the University of Minnesota [*University of Minnesota, 1945-2000*] where Clarke interviewed me and many others but Lyle French provided much institutional memory.

[chuckles]

DT: What was his leadership style like?

PQ: You would always leave his office feeling better. He got things done and helped with the town/gown. He schmoozed with everybody. He was a wonderful surgeon, a good guy, and a perfect choice for the position of vice president for the health sciences.

DT: I've heard that from other people, too, that they liked him. He was very congenial.

PQ: A North Dakota farm boy with great talent. He's the only one some of my friends could remember who could drive over the hill on the first tee at the University Golf Course, about 240 [feet] to the top of the hill, but Lyle could drive over the hill. He was good at everything he did.

DT: So much of the reorganization and expansion of the health sciences was contingent on the state appropriating enough money to support that expansion, and that Lyle French was crucial because he was well liked by the legislators.

PQ: Yes. Yes.

For example, we all took part in a continuation course in Florida year after year and Lyle was always wearing his straw hat because he didn't want to come home with a tan when he was meeting with a legislator. This was typical of his smarts, his street smarts or government smarts or human smarts. He had a wonderful wife, Jean. Those were good years. He was the right guy to get this going. But I don't know why they did it exactly, other than it was the thing to do. It was done well, getting it going.

DT: After the reorganization, did it change the day-to-day operations at all or did it change the degree of interaction you had with the other health sciences?

PQ: No. I think I answered sort of a question like that with Clarke or a questionnaire or something. I was so involved with my own stuff that I didn't notice a thing. It's like asking a fish to describe water.

DT: It didn't interfere with what you were doing.

PQ: It didn't interfere at all. I was chief of staff from 1979 to 1984. That was a period where AIDS [Acquired Immune Deficiency Syndrome] came to the U.S. I felt that I had some of the qualities that would not allow things to be polarized. It was kind of like when [Dwight D.] Eisenhower was president of the United States. Everything was kind of tranquil. We probably didn't do as much as we should...but, anyway, during my era, and that is kind of what I think of as Lyle's era, it was a peaceful time. The disaster of HIV/AIDS required changes in medical practice that were achieved.

DT: When you were chief of staff, was John Westerman still hospital director at that point?

PQ: Yes. He had a process for everything. When I was chief of staff, if a problem came across your desk, you had to tend to it, but it didn't take an awful lot of smarts to figure

out how you'd fit the problem into a process of some sort and solve it. That was a very smooth operation. John Westerman was a very capable guy.

DT: It seems like there were quite a few program introductions, innovations, in the 1970s, one of which was the establishment of the Program in Human Sexuality. I was reading a memoir recently about that and the individual said that you quite a supporter of the program.

PQ: Yes.

DT: Can you talk about your recollections about the program, maybe why it began and kind of your involvement with it?

PQ: Yes. It was part of the new curriculum. It was felt the behavior and behavioral things...that medical students should be more comfortable talking about sexual matters than they had been. So how do you go about this? Neal, I think, was the dean and Lyle was involved with it, as well. There was a Glide Foundation in San Francisco. That name or that organization came into the conversation.

It so happened that one of the pediatric residents was in my laboratory training to be a microbiologist. His name was Rick [Richard] Chilgren. He's the one that you've probably heard from. Rick was a very nice guy, and he was doing pretty well in the laboratory, but he wasn't extremely happy with the kind of work he was doing with microbes and neutrophils. I don't know who recruited him to be one of the leaders in this human sexuality but he was involved with the Glide people.

My support of Rick Chilgren was my only role in that effort.

DT: I read about the fact that a couple of the Regents got very upset about the sexuality, the SAR [Sexual Attitude Reassessment] seminars and that that had led to some problems with the Regents, but that were other people who were supportive.

One of the things that's interesting, that we are curious about, is the role... It seemed like the Lutheran Church was quite involved in getting the program established.

PQ: Yes, I think they were part of the pastoral chaplaincy program. I'm Lutheran and know those people but I'd forgotten that connection.

DT: We were thinking about whether we should try to interview Rick Chilgren and, then, we heard from some people that he might not be a good interviewee.

PQ: He's so erratic. The word I would use is obsession. He's sort of obsessed about the program here and how he left it. But I cannot, for the life of me, figure out how he left it and what the pathology was in his leaving. It left him scarred, so that he's obsessed with his Minnesota connection. The four people in Minnesota that... He trusted Lyle. He

really trusted Neal. He considered Doctor Michael and myself as his colleagues that he trusted.

I don't know if what I've said helps very much.

DT: It definitely does. It's very valuable context. We didn't have enough context, really, so it's definitely good to have this information. This is Eli's part of the project. He's really focusing on trying to understand the history of the program.

PQ: Yes. It was ahead of its time, I think, and it certainly was ahead of small town Minnesota. I still don't quite understand... I went to England about that time. In 1971, 1972, I was on sabbatical at Oxford. Was it after that in the 1970s that all this took place, after we were home?

DT: Yes. It was established in 1970, 1971.

EV: Nineteen seventy-one. I think the episode that you're referring happened in 1974 in the small town.

PQ: I was back then from England.

I think that we were in the midst of something then that was troublesome, and that was Lewis Wannamaker in Pediatric Infectious Diseases who had a program going at Red Lake at the Indian Reservation. Has that come up at all?

DT: No, but can you tell us more about that?

PQ: Yes. I was peripherally involved. Dr. Wannamaker was studying the role of streptococci in human disease and one of these diseases, glomerulonephritis, is common in Native Americans. Dr. Wannamaker had an epidemiologic program that got quite a bit of support since a strain of streptococci called the "Red Lake" strain was found to be related to glomerulonephritis in the reservation of the Ojibwas around Red Lake [in northern Minnesota]. This was a nephrogenic strain. A strain of streptococci which would infect the skin and cause glomerulonephritis. The Red Lake study was for prevention of glomerulonephritis. This study was ongoing at about the time the Tuskegee Syphilis Study was discovered. Dr. Wannamaker and everyone in our research laboratory were upset by accusations of experimenting on people. In truth all studies had been approved and accepted by all authorities with human subjects in research consent and by tribal leaders. In the few trips I made, there was Native American participation all the time. That's what was preoccupying me when we came back from England from that sabbatical in 1972.

DT: So you think a lot of that criticism that was made of the program and of Wannamaker was stimulated in part by the Tuskegee Syphilis Study or do you think there was something else...?

PQ: That was the background for the suspicion I suppose. When you had studies going on the effect of streptococci in the skin, I think the mindset of the people criticizing was just treat everybody with penicillin and, then, you would cure the streptococci. But it was more complex than that. The skin/kidney connection and the throat/heart connection were known. The publications that came out of that were clinically useful. Streptococci infection of the skin cured by treatment with penicillin and prevented kidney disease. It was a very fascinating kind of thing.

DT: Who were the people who were criticizing? Where were they from?

PQ: I do not know. It hurt Dr. Wannamaker so deeply we were all very sad.

DT: Do you know anything about the transexuality surgical work that was being done?

PQ: No, only the characters that...it was Don Hastings and Al [Albert] Sullivan. But I don't know anything further than that.

It just seems so bizarre that that was going on, but it was. It didn't reach the councils that I remember. One of the things that I was involved with on the national level was getting human consent for research and the Institutional Review Boards and things. I was active at the NIH when those things got started. I know nothing further, except these two nice guys: Don Hastings a terrific guy, the head of Psychiatry; and [Al] Sullivan was one of the associate deans, were friends. That's about all I know.

DT: One of the other programs I was thinking of was the Ida Martinson's Homecare for the Dying Child Program in the early, mid 1970s. I wondered if you had an involvement with that seeing as it tied so much to Pediatrics.

PQ: No. I know Ida real well. She's part of the Institute of Medicine and her work in Hong Kong and all of that and her husband, Paul, are friends, but I don't know anything about her hospice work.

DT: Interesting. She mentioned that John Kersey was kind of the primary person she was working with.

PQ: Oh, yes. They're neighbors, so that makes sense. You interviewed Ida?

DT: Yes.

PQ: She's a wonderful person.

DT: Yes, she's wonderful, a real pleasure to interview.

I saw that you were on the search committee for a new chair of the Department of Obstetrics and Gynecology in 1976.

PQ: Yes.

DT: Do you remember anything about that, the appointment of Konald Prem as the chair?

PQ: Yes. Yes. I do. He was just kind of an inside appointment and sort of a natural. He was the leader of the department at that time. As far as I know, his being Catholic and his views on training people to perform abortions came up. I remember it was a good discussion, and that was that. That was no longer a consideration, and he was appointed the head of the department and had, I thought, a very successful time.

DT: That's the reason I bring it up, because my understanding from what I saw in coverage in the *Minnesota Daily* and maybe the [*Saint Paul*] *Pioneer Press* was that after his appointment the pro-choice groups protested his appointment...

PQ: Yes.

DT: ...because of him being Catholic and whatever views he held on abortion. Your recollection is that wasn't so much of a conflict is interesting.

PQ: Yes. I thought that was handled very well and to the satisfaction of everybody on the search committee. I think of that as one of the smoother operations.

[chuckles]

DT: We talked earlier about how important the NIH was, is. One of the things that's striking from the mid 1970s onwards is that first [President Richard] Nixon and, then, Jimmy Carter were intent on cutting how much federal funding was going to medical education and research, and there was massive retrenchment in the early 1980s. How did that affect the Medical School, in general, and your own research practices?

PQ: Well, again, I have to go back to my over all impression of the NIH as being a wonderfully responsible organization and an important reason why medical research has been able to accomplish what it has in this century, in the last half of the twentieth century. So I just have this strong golden glow all over NIH.

[chuckles]

PQ: It was so generous when I started. I, somehow, had enough wit to know that wasn't going to last forever. We had to work *very* hard for applications and with our progress reports. It consumed a great deal of energy for us to do a good job so that we'd be supported. We were able to land a training grant in Pediatric Infectious Diseases right about that time. So I would say for me, personally, that we didn't notice it, kind of like as we started this, I didn't notice the Depression. And I didn't notice the depression the second time either.

[laughter]

PQ: Things went along pretty well. We knew that the scores were much more difficult to obtain, but we did.

I guess I'll say that when the last training grant renewal, the last renewal for my own research, would bring me to age seventy-four, I was the happiest person on the planet for a while, knowing I'd *never* have to apply again.

DT: [laughter]

PQ: This was my last, last competition. I'd forgotten that. I'm glad you asked that. Just last night, I was reading in David Brooks about how you have to have something so that it's challenging enough that it's difficult in order to do something... I've kind of forgotten whether it has to do with happiness... That maybe is the happiness chapter. Those were the days. Those were our challenges. Those were the mountains we had to climb all those years. I must say that I, personally, was just *so* happy that I'd done it for the last time. Since seventy-four... I'm eighty-six so that's twelve years that I haven't had to do that. No wonder I love this place.

[laughter]

PQ: That's my story.

DT: You mentioned a little while ago about HIV/AIDS [Human immunodeficiency virus/Acquired Immune Deficiency Syndrome]. Given that you were/are an infectious disease specialist, how did the arrival of HIV/AIDS change or influence what physicians were doing and what you as an infectious disease person was doing?

PQ: Yes, it was dramatic. It was a dramatic change. Just before that, we had the feeling that infectious diseases, although not eliminated, were able to be contained or handled. There would be epidemics and there would be other things, but there was a sense that we were in kind of a steady state with infectious diseases. In fact, one of the leaders—his name is Robert Petersdorf; he was head at the [Department of the School Medicine] University of Washington, and, then, I think he was at [University of California] San Diego at the time—felt at our infectious diseases meeting that infectious disease people would have so little to do that they'd probably have to swab each other's throats in order to keep their days from getting boring.

Then in 1981, it was in MMWR [Morbidity and Mortality Weekly Report]. I was chief of staff at that time. I was sitting in my office and I got a call from a colleague at the Sloan-Kettering in New York. He said, "Paul, I've just been talking to our colleague, [Paul] Wolberding in San Francisco." Don Armstrong was at Sloan-Kettering. He was head of infectious disease there. He said, "They're seeing young men dying and they have Kaposi's sarcoma. And I'm seeing that here," because of the cancer. "They're dying in their early twenties. Are you seeing that in Minneapolis?" I said, well,

remember, Don, I'm a pediatrician. I truthfully haven't heard that my colleagues in internal medicine are seeing this." That was the phone call and, then, within a couple weeks, we got this MMWR describing the men who had sex with men on both coasts. They didn't know the ideology. I remember in groups, they were wondering about this disease. It acted like a viral disease. So I remember those conversations.

When they discovered the retrovirus, that made sense. Then, another colleague who was at Cleveland at the time, [Charles] Carpenter, said that there was something in Africa called Slim disease that sounded very much like it, and they had Kaposi's sarcoma. So that was Slim disease in Africa. At one of our meetings, he said we should do something about that in Africa and see if there was a connection. Well, I happened to be president of the Infectious Disease Society of America in 1985 and it [the meeting] was in Minneapolis, and we brought in Robert Gallo and Luc Montagnier, who both identified the virus and called it HIV, the human immunodeficiency virus. As early as 1985, tremendous work had been done. The virus was identified. It was named. It was expected that a vaccine would soon follow. I had to get this in there first.

In terms of your question, I was chief of staff, and we had problems with some surgeons not wanting to operate. We had other surgeons saying, "You are cowards." This is the way surgery has always been with infectious disease, so it was *very* dramatic and the councils were meeting here at the hospital. I was made chairman of the blood—I don't know what they called it—committee. We had meetings. Other than those two little episodes of a little shouting, everything settled down. We had a system. Surgeries were being done. Strict isolation for our patients was organized. It just worked. As more information came in, we accepted it. Then, gradually Minnesota got to have more and more HIV indentified. It was a little bit more difficult to grow the virus and finding antibodies. We kept pace with the two coasts at that time.

DT: At what time did you start seeing HIV in children?

PQ: Very soon...very soon. Children were dying. They could identify HIV and in my clinic, we had some children with HIV. The antiretroviral treatment soon got to be available. I, personally, wasn't involved with any child who died, but we were treating children with antiretrovirals. Then, it wasn't long before there were no children being born with HIV anymore because of we could treat the mothers before their babies were born in the U.S. and Europe, and finally in Africa.

I was appointed to the Elizabeth Glaser Pediatric AIDS Foundation in the mid 1990s. By that time, we were establishing this maternal/child transmission program in Africa. When I stopped being on that board, the Glaser Foundation supported some 300 clinics around the world.

So I watched our problems and progress with HIV/AIDS since the phone call in 1981 until now. We still have a long way to go to get a successful vaccine. That's my involvement in it. It's been pretty dramatic.

A great afternoon of my life was in Kampala [Uganda] in 2008. They had just gotten antiretrovirals for the children in the pediatric hospital in Kampala. So the children in the children's clinic when I was there in March had been cured or the HIV virus was not not detectable in their blood. They were just normal kids. Until October, just a few months before that the clinic was where the children infected with HIV came just before they died. Once the clinic got the antiretrovirals, they became normal kids.

HIV was the most terrible death sentence and it must have been like in the days when they started understanding syphilis. It was a sexually transmitted disease and a chronic disease. HIV is much more toxic in terms of the drugs that are necessary. But, it's very much like the story of other... We learned a lot from reading the New York public health people when syphilis was being handled by the Public Health Department. This turned out that internal medicine were the heroes here, people in San Francisco.

One of my all-time heroes is Merle Sande, who was at San Francisco at that time. He died recently of a malignancy. He was the one who showed the way for compassionate and palliative care. In New York, it seemed intensive care efforts were used when death was inevitable. Merle had the ability to convince the powers that be in San Francisco about compassionate care of people with AIDS.

Then, it was a field day for infectious diseases, because immunodeficiency virus had left them susceptible to tuberculosis and all the fungal, meningitis, and the rest of it. Once the antiretroviral cocktails were available, life of HIV infected people became more normal.

DT: I know that HIV activists had played a really prominent role in the history of HIV/AIDS and in shaping clinical trials and patient access and the attitudes toward HIV patients. Did you have any encounters or what's your perspective on the role of the HIV/AIDS activists in this history?

PQ: Oh, I think they've been a necessary part, i.e., maintaining the attention of the public. You need the activists in order to keep something in the headlines and keep it where the funding is stimulated

This White, one of the children...

DT: Ryan White [Ryan White Comprehensive AIDS Resources Emergency Act]?

PQ: Yes. The Elizabeth Glaser Foundation] is another good example. Do you know of that organization?

DT: It's familiar, but can you say a little bit more about it?

PQ: Elizabeth Glaser was an actress and her husband, Paul Glaser, was in *Starsky & Hutch*. Anyway, she was given a transfusion after her first child was born and, also, after the second child was born. Both of the blood transfusions given to her—this was in the

1980s—had HIV virus. So Elizabeth and both of the children had HIV/AIDS. When she died, Paul and her friends around the kitchen table started the HIV [foundation], the Elizabeth Glaser, G-I-a-s-e-r. They put me on the board after I think it had been going for a few years. This is a dramatic example of the power of activists.

Minnesota became organized rapidly with Frank [S.] Rhame, the infectious disease specialist, and [Keith] Henry at Hennepin County [Medical Center]. Just as soon as therapy was available both children and adults in Minnesota were treated. Again, a shining example. I think the care that these people needed was here for them. The churches and everybody stepped up to bat. I gave some talks about HIV and AIDS at churches and the [University of Minnesota Alumnae Association] and the Great Decision Program. It seemed like everybody wanted to be critical of the government and critical of the medical profession during that time. I think we did a really admirable job with what we knew at the time. I think Minnesota came through as it usually does. [chuckles]

DT: Well, I just have a couple more questions if you...

PQ: Sure.

DT: You talked earlier about your involvement with the Biomedical Ethics Center and that you were the first director.

PQ: Yes.

DT: Can you tell us what led to the establishment of the Center of Bioethics?

PQ: Yes, it was the power of the medical students. University of Minnesota medical students had organized a bioethics noon lecture series for a long time. The program had been going at least four years. Neal Vanselow was Lyle French's successor and supported the students. Neal was convinced that we needed a program in bioethics. Dave Brown was the dean. The Northwest Area Foundation came through with, I think it was, \$100,000 or some large sum of money. It takes money to get these things going. Dave Brown asked me if I would be the sort of organizing director for a while. Why I said, "Yes," I'll never know. I just finished being chief of staff and I can't say, "No." I jumped into this field of bioethics. It was amazing how we got it started. It wasn't totally smooth. There was some resentment that a pediatrician, an M.D. who wasn't even a philosopher should be given the responsibility. I read philosophy and read ethics. It was the hardest period of my life, actually, to get that going because of the subtle resentments I felt. However, we got a Center for Bioethics.

DT: Who was the resentment coming from? Other physicians or other ethicists?

PQ: Nothing overt from anyone really, probably my own insecurity.

This is what happened to me as first director.

We put on a program on HIV/AIDS at the Radisson [Hotel]. There was Tim [Culbert]—oh, gosh, I've got to give him credit—who is now in Pediatrics in private practice but a medical student at the time. He was my *lifesaver* because he had lots of energy and we got that program off the ground. It was the first program ever on HIV/AIDS. My old Northfield High School classmate, Professor Homer Mason, who was head of the Philosophy Department at the time, wrote a nice paper about the most vulnerable are the people who deserve the most attention. It was a successful program.

The hero in all of this is Dianne Bartels. Dianne was recently honored at her retirement. She and myself, and Tim Culbert were the work horses. As I said, in one of the reports, the thing that I'm most proud of is having a program established enough so we could attract Art Caplan. Art Caplan came here from the Hastings Center, and that's when the bioethics program got going. Dianne kept it together. So I was the lightning rod at first and had enough attention. I reported to all the deans of all the schools in the health sciences and the College of Liberal Arts and sent them progress reports and that sort of thing, but we are indebted to Dianne and then Art Caplan and now Jeff Kahn.

It was student driven, got funding, and we were able to attract Art Caplan, one of the stars. Then, Susan Wolf came here and, then, Jeff Kahn, who was from Wisconsin. It's terrific. But it was the students. I give them the credit.

DT: That's what I thought. My sense from reading the archival material was that the students had been wanting bioethics in the curriculum for years.

PQ: Yes, yes.

DT: I was curious why you were appointed. You mentioned earlier that you were involved with informed consent and getting institutional review boards up and running when you were on various NIH committees. Could you say something about that and do you think that influenced why you were appointed as director?

PQ: I don't know. I don't know if there was any connection there. That was kind of separate from my University activities. I don't know why I was appointed, actually. Dave Brown was the dean and Neal Vanselow was the vice president for health sciences, they were the two who asked me to serve. I don't understand exactly why. I guess it was a challenge for me after being hospital chief of staff for five years.

DT: A lot of the Medical School's history is so related to the view that the Legislature has had toward the school and the work that it's doing. I wonder if you have had any encounters with the Legislature. Then, also, was it your brother [Al Quie] who was Governor? Did that in any way, do you think, shape or have any influence over the standing that the Medical School had with Legislature?

PQ: I don't think so. Lyle was chief, was our vice president when Al was in the Governor's office, and John Westerman. Those were good years. I kept it just totally separate. My brother and I never talked about the hospital or the Medical School. He

never asked me. He'd been in Congress for twenty-four years and the Mayo Clinic was his lobby. So, even then, he didn't ask me anything about medicine. Nobody in my family asked me about it. My father, if it wasn't in the *Reader's Digest*, he didn't believe it.

DT: [chuckles]

PQ: That's kind of how I functioned. My brother left me alone and I left him alone. I was one big blotter. Everyday or many times a week, people would give me messages to give to my brother. I would always smile and never say anything. I'd tell everybody that I knew, "You know, I'm just one big blotter. I just absorb all of this." So that's all I can say about that era.

I want you to know one thing, though, and that is about RPAP.

DT: Oh, yes. I didn't know you were involved with that.

PQ: I was, yes. I was *very* involved with RPAP. That's the Rural Physicians Associate Program. Jack Verby and I were close, close in many ways. I supported RPAP from the very beginning. From our earlier conversation, it's obvious why I did; because I'm a farmer. Rural Minnesota means a lot to me. Jack and I got to be *really* good friends. Jack is another one of these marvelous... I talked about the scientific in the department strength. Jack had the qualities that allowed this to happen—again, Minnesota. It's not somebody saying that we should do it. It was Jack doing this from the ground up. He was a remarkable guy. He was an athlete. He had sort of baseball metaphors. He was able to schmooze with the Legislature, schmooze with the physicians out in greater Minnesota, get smashed up in his Volkswagen and, yet, he was out there all the time. He is a hero in my mind. He wasn't recognized very much. He was kind of a controversial figure in some ways with the department, but he was a great hero who got this thing going. It's thirty-five years now. Forty students go out there and spend these months. He needed *my* support—I'm going on about my support—because he didn't get much support from the faculty. As chief of staff—I don't know exactly that what I'm saying is that important—I felt one of my contributions to Minnesota has been my support, from the beginning, of Jack Verby. So for twenty straight years, I always went up out once a year to one of these places as the visiting professor. That's how it was set up. It had money; it had money from the Legislature. It had money from the practitioners. The students went out there in these smaller towns: Willmar, Northfield, Faribault, and Red Wing, all these places. It thrived. The amazing thing is that on all the test scores—we're numbers oriented in science—all the residencies and all the rest of it they shone. The RPAP students were as successful, whatever that is, as the rest of them. It was a very positive program.

DT: I'm glad that you brought it up. I hadn't realized...

PQ: They had an RPAP Advisory Committee that I chaired for about twelve years. [laughter]

DT: It seemed like an incredible program when it began and it fit an important niche that you had... In a way, it's different that the town/gown relations, but it spoke to an issue that a lot of private practitioners were feeling, that everything was focused in the city centers and that Minnesota was a rural state, and that there was a shortage of physicians going out into rural areas.

PQ: Yes.

DT: So this seemed like such an important innovation.

PQ: Yes. I guess I mentioned it. I sounded like I neglected the town, but I really can hold my head up because I did support... Jack got obsessed, I think, with the critics. It's hard to be criticized. It is for any human. Jack was criticized and took a lot of guff from the academy. I saw him through thick and thin. I spent *hours* with him—that, you don't have to mention. I just feel very proud of that.

DT: Is he still...?

PQ: No, he developed Alzheimer's [disease] quite soon after he retired. He had a wonderful wife. He had a few years, but he died some years ago. Yes.

DT: That's too bad.

That's really important that you have that in the record then, very much so.

PQ: Yes, I'm so glad it's in the record.

[laughter]

DT: Is there anything else that you would like to share?

PQ: No. You've let me go on and on. I admire your patience here.

DT: You've had great stories.

PQ: [chuckles] Well, thank you. Thank you. This is good.

DT: I really appreciate you taking the time. I'm glad that you're retired, so you could give us all these hours.

[laughter]

PQ: Yes

DT: Thank you.

PQ: Good. This was nice.

[End of the Interview]

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