

Robert Geist, MD

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

Robert Geist was born in St. Paul, Minnesota, on May 4, 1928. He attended the University of Minnesota for his undergraduate and medical degrees. He received his BA in 1951, his BS in 1952, and his MD in 1954. He did a one-year residency at the Washington, DC General Hospital and then returned to the Minneapolis Veterans Administration (VA) Hospital to complete his residency in urology. Geist went into private practice in 1960, where he initially worked alone. In 1968, he went into group practice with two other urologists. This group practice grew over the years to six urologists. In 1994, this group practice merged with another practice, became known as Metro Urology, and grew to include more than twenty urologists, including many with subspecialties. Metro Urology's only link with the UMN is through pediatric urology, with which Geist was involved. Geist retired in 1997, but returned to the VA for three years in the urology department because of a shortage of urologists. He also served in the Army after graduating from high school (1946-48).

Interview Abstract

Geist first discusses his background, including his education. He then discusses his residency at the Minneapolis VA Hospital. He describes going into private practice, his experiences building his practice, the challenges he faced, and his relationship with the University of Minnesota. He discusses women in his medical school class and in urology, the impact of the introduction of Medicare and Medicaid, the concerns over the shortage of doctors in the 1960s, and the increase in the UMN Medical School's class size because of those concerns. He discusses some of his involvement in medical politics since 1973, including his experiences with HMOs after their creation, with the Minnesota Medical Association, and with fee-splitting and referral practices. He reflects on the relationship between St. Paul and Minneapolis physicians and between them and the UMN, including the contentious politics between some St. Paul doctors and the UMN in the 1960s, particularly in relation to the attempt to establish a St. Paul medical school.

Interview with Robert Geist

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed on November 4, 2009

Robert Geist - RG

Dominique Tobbell - DT

DT: Welcome. This is Dominique Tobbell. I'm here with Doctor Robert Geist. It's November 4, 2009. We're interviewing in my office at 510A Diehl Hall [University of Minnesota.

Thank you, Doctor Geist, for joining me today.

RG: You're welcome.

DT: I am saying it correctly. It's Gīst?

RG: You're saying it exactly right.

DT: Excellent. I had to ask check with Claus Pierach before I called you.

[laughter]

DT: The German names.

RG: You remember the *Zeitgeist*?

DT: Yes.

RG: Or *Poltergeist*?

DT: Yes I had to keep saying it in my head to make sure.

[laughter]

DT: I know when we spoke on the phone, you gave me some of your background, but just for the record, if you could tell me a little bit about how you came to study medicine, where you studied it, and what not, just that early background.

RG: It's funny, I was thinking about that today only because I was looking at the *JAMA* [*Journal of the American Medical Association*] which just came in the mail. I opened it up, and there is a picture of Morris Fishbein. Morris Fishbein was the editor of the *JAMA* from 1924 to 1946, or something. I remember when I was a kid—my sister was in med school—and I probably was home sick, so I was listening to KUOM, the old University [radio] station. It had different letters at that time. I suppose it was probably in the late 1930s or early 1940s, so I was just a youngster. I remember I heard him give the convocation at the University. I still remember, almost as if yesterday, how he got me enthralled with medicine. He was walking down the street and an ambulance came up, a man in a white coat with a stethoscope jumped out and helped the person who was lying on the sidewalk; that's what he wanted to be—a hero in a white coat; it put him into medicine.

DT: Wow!

RG: That was *his* story. Then, I remember the other quip he made about making fun of advertising, like “eat white bread and you'll be dead,” or if you don't eat white bread, you will be dead, whichever it was. I remember it was such a wonderful, clever speech. My sister was in medical school, and she was a tremendous influence on me—she's quite a bit older—and I think that's what sort of got me going was really family, but that talk by Morris Fishbein probably clicked more than anything else.

That's interesting.

DT: It is.

RG: I was just reminded of that today, otherwise, I would have forgotten about that.

DT: Well, I'm glad you were reminded.

So where did you study medicine?

RG: At the University of Minnesota.

DT: What years? Oh, I have them on your CV [curriculum vitae].

RG: I graduated in 1954. At that time, they gave the M.D. a degree when you graduated, unlike my sister, who was the Class of 1941; she had to go to an internship before she got her M.D. Yet, she was only twenty-one when she got the M.D.

It was a lot easier then, I think.

[laughter]

DT: And you tell her that all the time!

RG: Or I was dumber or whatever.

DT: Where did you do your residency then?

RG: Urology was done at the University and Veteran's [Administration] Hospital, rotation.

DT: How were your experiences at the V.A. in your residency?

RG: Well, I thought they were wonderful. We had a wonderful chair of the department when I was there, a man named Julian Ansell. Julie and his wife became close friends, even though he was my boss, if you will. He was just a wonderful person and was certainly a great mentor to me.

What happened is before my senior year, Julie became the professor and chair of the department at the University of Washington, so we didn't have a chief. It turned out then my chief was a very close friend of mine from Medical School named Roger Haglund. Roger was a year ahead of me in the residency because after internship, I had started a residency in Washington, D.C. General Hospital, which was a very poor residency. When I recognized that, I opted to come back to the University after the first year. So I had to repeat the first year. That made Roger the class ahead of me. Still, we were then, and still are, very close friends. In fact, he visited me at our cabin last summer on his way through to Duluth to see his family. So we're still very close.

Anyway, it was a great experience at the V.A.

At the University, we had a professor, Doctor C. D. Creevy, C. Donald Creevy, certainly one of the prized and greatest men I ever knew. He'll always be purely Doctor Creevy to me, no first name or anything like that. [chuckles] He was the quintessence of a great professor, a wonderful teacher. My brother-in-law and sister, who are both doctors, always criticized me after the residency for talking about nothing but Doctor Creevy every other sentence.

[chuckles]

RG: That's an exaggeration but some, of course, is true. He was certainly a truly great man.

At the time, the staff person with him was Milton Reiser. Milton was a truly brilliant guy. As somebody once said, Milton was always running in four directions at once and the only person capable of that.

[chuckles]

RG: Of course, we called him Miltown Geysler.

DT: [laughter]

RG: Miltown, remember, at the time was a psychiatric drug to calm you down. Geysler, of course, described his personality, so he was Miltown Geysler. Anyway, Milton was a very fine man and a very good urologist. So that was the faculty when I was here.

We, also, had a Filipino man who was a chief resident when I was over here. He was a nice kid. I think he got... Well, I won't say. He felt brutalized; although, it was just his personality that kind of prompted people to jump on him. [chuckles] He was a nice kid. I might add that once he graduated out of residency, he quickly gained fifteen pounds.

[laughter]

RG: Anxiety type.

Anyway, the residency was a very good one. One of the interesting things...we used to show the slides for Doctor Creevy when he gave his lectures to the Medical School students. The professors in my day gave the lectures. I don't know if they still do; I hope they do. Doctor Creevy always gave them, and we did the slides. Of course, that was an education for us. At the time, we didn't appreciate that, but, of course, it was. We had a very fine residency program.

It's interesting... The other professors did lecture to us. Doctor [Owen] Wangenstein in surgery, Doctor [A.B.] Baker personally did the small classes and the big class would be in the big lecture hall...Doctor Baker, neurology. Doctor Baker probably was the most impressionable lecturer.

In our sophomore year, we had a wonderful professor of neuroanatomy, a world famous man, Doctor [Andrew Theodore] Rasmussen. Doctor Rasmussen was famous for going to the blackboard and taking the whole blackboard and with two hands draw perfect pictures at the same while he was talking. Of course, that was wonderful, and we had a great course.

When we got to Doctor Baker's class the next year, his first lecture was he looked out at us, didn't say a word—he had a fierce look, by the way—gave us a fierce look, turned around to the blackboard, and we couldn't see what he was doing. He was doing something on the blackboard. He turned around and put out his finger and said, "That's the true size of the spinal cord." You could barely see it on the blackboard—unlike Doctor Rasmussen. [chuckles] At any rate, Doctor Baker was a wonderful teacher for us medical students. For example, his way of teaching was very dramatic. We'd go into the small group, maybe twenty of us, and we'd have somebody assigned, a medical student, to give a case history. The person would get up and say, "This thirty-year old female..."

Then Doctor Baker would say, “Stop!” We’d all think, “what now?” [chuckles] Then, he would look down at the roster, and he would call on somebody in the class, and say, “What’s the diagnosis?” We would spend the next hour with no more history than the age of the patient and the sex. “What’s the diagnosis,” a differential diagnosis, one heck of learning experience.

DT: Sure.

RG: What you could do and properly do in a differential diagnosis, a very dramatic teaching method. But that was his way.

Many of our other professors were just wondrous lecturers, too. Doctor Wangenstein was always fascinating. He was fascinating because he would get up and tell you about a case history that he had on a rainy day, a Friday in 1924 or 1932 or something. He didn’t come here as a professor until 1932. Of course, we all thought this is real baloney. It turned out that somebody went and checked on the patient’s chart one time, and found out that, indeed,—they didn’t know if it was rainy or a Friday—he did really have the patient at that time.. [chuckles]

He was a very fine lecturer, and he gave us great classes.

Doctor C. J. Watson in Medicine gave wonderful lectures.

Of course, when we graduated, we all thought we should find a case of porphyria somewhere. In every hundred patients there probably were two or three. I remember working all my life and I never saw a case of porphyria until I was reading in the *New York Times Magazine* section this last week on Sunday. There was a case that was presented. These columns are written by a young doctor out in New York, always wonderfully written. She gives you the case history, and everybody booted on it. They couldn’t figure it out. Of course, it turned out to be a case of porphyria. That’s the first case I ever saw.

[laughter]

RG: I couldn’t diagnosis a case even when she wrote it up accurately.

At any rate, Doctor Watson was just a wonderful teacher. You mentioned Claus Pierach a while ago. Of course, Claus was mentored by Doctor Watson.

We had a lot of good undergraduate teachers. Doctor Maurice Visscher in physiology. That was in Medical School the first two years.

Also in physiology was Doctor Nate [Nathan]... Oh, I’ve got a blank. Doctor Nate Lifson, L-i-f-s-o-n. I think that’s what tipped me going into urology. I attended a couple of his seminars. I’d never been in a seminar. It was so great to see how that interaction went with his students, his physiology students, and some of the medical students were

there. Of course, I didn't know anything. I was just fascinated with the way he did it. Then, since it was renal physiology—he was the expert—I became interested in renal physiology. I think that's what tipped me—I wanted to be some sort of a surgical specialist—into urology. Albeit, renal physiology had very little to do, as it turned out, with urology, some, but not a lot. Renal physiology got me interested in doing a lot of reading on it, and I came up with some half-baked ideas which were all baloney, as it turned out. I think that was what tipped me personally into urology.

DT: That's good, because that was going to be my next question.

RG: Okay.

DT: I'm glad you corrected me.

Do you remember, were there any women in your medical student class?

RG: Yes, indeed. We had a wonderful group of ladies. There were probably no more than eight or nine. At that time, as you know, it was rare. In my sister's class in 1941, I think there were five or six out of maybe 100 or 108. Our class was 115 with about seven or eight.

The top student in the class was a lady from Duluth. By the way she was still alive at our fiftieth anniversary but too ill to come. I talked to her family and she, subsequently, died shortly thereafter. She had strokes. She was a wonderful lady, a brilliant student.

We had one student drop out who had led the class. She was probably the topnotch student of all time in the Medical School, and she suddenly dropped out after the sophomore year and went into research of some sort. I don't know what her fate was. I don't know why she dropped out, but it was kind of curious when somebody did.

Otherwise, the rest of the ladies, I just thought they were wonderful people. When we'd see them at an anniversary, it's always great to see them, too.

DT: Yes, excellent.

RG: Speaking of ladies in medicine... I went out of my way to make sure that my group in Saint Paul hired the first female urologist in St. Paul.

There was a lady at the University in the residency and who had graduated here and was working in Minneapolis. I wanted her to come over to Saint Paul instead of Minneapolis. It turned out she was, I think coming back to the University, and ended up at the Mayo Clinic, where she is now. She was really the first female urologist outside of academia.

DT: What was her name?

RG: Deborah Lightner. She does female urology at the Mayo. I don't think she was happy with that because she was really had much bigger interests. I think oncology was her chief interest.

Eileen Toolin was a resident that graduated out of the Mayo. She had been there on a fellowship in renal transplantation, and, then, we recruited her for our group going back in the 1980s.

After that, of course, I think we got a lot more lady doctors. That's been a great boon to mankind and, especially, *womankind*.

[chuckles]

DT: How do you spell Eileen's surname?

RG: T-o-o-l-i-n. Her married name is Puig, P-u-i-g.

DT: What led you to go into private practice?

RG: I never thought of ever going into academic medicine. I don't know why. I always thought I wanted to go into private practice. I never had any interests otherwise. I went to talk to Doctor Wangenstein when I was a senior and asked him about a surgical residency, and he asked me what I was interested in. I said, "Well, I want to go into private practice." That was *not* his interest.

DT: [chuckles]

RG: That was an undiplomatic thing to say. He was training University professors, and rightly so. That was what they do at university academic centers. At any rate, I didn't apply to the program. I was smart enough at least not to do that. [chuckles] His goals for his department were different and mine were different. Fine. I did what I wanted and he did what he wanted; no problem.

DT: Was it natural for you to go into solo practice? You said you initially went into your own practice.

RG: I started my practice in 1960. At that time, doctors were *extremely* busy—not that they aren't now. They were, also, extremely busy then. I never even thought really much about joining somebody else, which is the natural sequence now, but then, it was not. I remember starting up and what was very interesting to me... I had a wife and a couple kids and I had to borrow money. We lived with our parents actually, her parents and my parents. I remember we borrowed money for at least eighteen months while I started practice. I would go to *every* meeting at *every* hospital trying to figure out where my niche was going to be, so I met a lot of people. I, finally, settled on two hospitals: the old Miller Hospital and the Bethesda Hospital. The reason was they both had educational programs, internships, and that attracted me greatly. I was interested in relating to the

younger group coming in, the younger doctors, and, also, talking to them about urology. I went everywhere.

The only problem with not doing much work when you're first out solo is you're worried about your talents atrophying. See, in your residency, you think, oh, geez, I'm pretty good, you know.

[chuckles]

RG: Maybe you weren't, but at least you thought so. That was the only thing that bothered me was the lack of doing what I was trained to do. Then, about a year after I started practice—I looked back and I remember—in June 1961, I said to my wife, "Do you realize I've seen one new patient each day this month?" But I had not had one case come out of it, even for a simple cystoscopy. It was a zero. But, I said, "You know, I sense that something is happening." After that, my practice increased geometrically, actually. So it was an interesting first year.

DT: Yes. Obviously, there were challenges then about getting patients and the finances. What other challenges did you face?

RG: By the way, the reason my practice went so fast was I would answer a consultation today. If they asked for another urologist to see a patient, it would take at least two or three days and, then, they often did not communicate what they wanted to do. They just went ahead and did what they did and that was that. My way was I'd see them today. You'd know what I thought. We do the case tomorrow if there was a case to do—this was a hospital consultation. Bingo! we could move along. At that time, people would remain in the hospital just waiting around for doctors to make rounds the day after tomorrow, nothing like today or after the cost problems really hit. People would just sort of sit around in hospitals doing not much useful one way or the other. At any rate, that's how I built my practice, just being much more timely.

The other urologists all were excellent. One guy was not trained as an urologist who did urology who was really...well, who knows? RIP. Rest in peace. But all the rest of the urologists were wonderful, and they were all so nice to me.

My experience going into practice might be of interest to you. It's not related to the University. Is that all right?

DT: Yes, absolutely.

RG: When I was going to go out into practice, I wondered where would I practice. I had people in South Dakota who wanted to meet me. So I went out there and came back. I remember coming into town thinking this is where I want be. [chuckles] There was nothing out in the Dakotas that interested me.

[chuckles]

RG: It was flat and windy. Also, it was springtime and there was no snow on the ground, but nothing was green.

So I came back into town, and I remember that spring, I went over to see Doctor Fred Foley, famous for the Foley catheter. He was a neighbor of ours who actually lived around the block from my house. So I knew him, and I knew him because he was always at the Twin City Urological Society meetings. He was also a heavy weight there. At any rate, I went over to Doctor Foley, and I said, "Doctor Foley, I just want to say, 'Hello.' I know you retired last year. I just wanted to get some advice from you." So we had a nice talk. The first thing he did was say, "Would you like a drink?" [chuckles] I said, "Sure." He came out with a huge tumbler full of straight Scotch...

DT: Ohhh. [chuckles]

RG: ...with a couple of ice cubes in it. He sat there and was swallowing it down fast, and I didn't know what to do with mine. I wasn't much of a drinker. I don't remember if I found a potted palm or what, but at least I didn't end up drinking it.

My question was, "Doctor Foley, I wonder what to charge people. I know what Doctor Creevy charges." We used to enter the charges in the books for Doctor Creevy. I said, "I've been around and talked to Doctor so and so and so and so, and they told me what they charge. I certainly don't want to charge more; I know better than that, and I don't want to charge less as if I'm trying to undercut them, and so forth. I wonder what you think." There was a silence. He looked at me and he said, "Robert..." He never used nicknames. "Robert, how much is a human life worth?" [spoken slowly in a deep tone] That was the end of that conversation. [laughter] I found out later that he was a Robin Hood charger. If he thought you had a lot of money, a TUR of the prostate might be \$1,000, which in this day and age probably is \$10,000. I remember Doctor Creevy charged probably less than one quarter of that, if I remember right. At least what I found out how he thought.

[chuckles]

RG: I can't remember your question.

DT: What kind of challenges you faced in those...

RG: Other than trying to get that glass of Scotch drunk?

DT: Yes.

RG: Okay. The challenges of private practice were to build a practice.

After about a year or two, another young man came out and decided to practice in Saint Paul. I said, "Geez, Jerry, join me." Jerry McEllistrem. Jerry was and still [is] a very

close friend, and we had an office, and we, literally, had a desk just like yours here, except it was open on both sides. He was on one side. I was on the other, and we had two telephones. We had one secretary out in a small waiting room. That's how we set up practice. Later, we moved over across the hall to a bigger place. I remember our desks were side by side. That was really bad for our wives and families, because, after we'd seen all our patients, we'd sit there and we'd talk urology and talk about everything and laugh and laugh. Then, we'd look at our watches, and it was seven-thirty instead of six-thirty. One of the nice hardships of starting a practice was having good friends to practice with. Jerry never wanted to be a partner.

As time went on, by 1968, I realized that I had no life. I was working all the time. If you went on vacation, you'd shut your practice down a week before, so everybody would be out of the hospital. You didn't want to dump them on somebody else. Then, you'd come back and it would take another week before you built your practice up. So a one-week vacation was three weeks.

Also, working so hard, since you're on call twenty-four hours a day, seven days a week, 365 days a year, I thought, well, this is nuts. I thought I'll become a partner with somebody. I looked around and Doctor Foley's old partner, Doctor Eddie Richardson, was a natural because he was going to the same Miller Hospital as I was. We'd never been rivals; we'd always gotten along very well together. He's a wonderful man. So I thought I'd like to go with Eddie. But we needed a third, at least. There was no third around town, so it was obvious a resident was somebody we would want. I'd kind of looked over the resident crop coming out and saw Doctor Stan Antolak [Junior] and thought he might be a good choice.

So we had a party at our house. I took care of part of a residency program at the Gillette Hospital for Doctor Creevy. He had sent us a resident from the University and from Saint Paul Anker Hospital, at the time. So as they graduated out of the Gillette part, my wife and I would throw a party. Doctor Creevy would be there and all my fellow colleagues who I sort of enlisted as part of the faculty, if you will. I remember I wanted to talk to Eddie about becoming a partner. Everybody had left. Eddie stayed. Eddie was known to take the sauce a little bit, so he was sipping the sauce. I remember it got to be... I wasn't going to ask him first. I knew he wanted to ask me to be a partner. So I waited and waited and waited and the sun started to come up. Eddie, suddenly, put the glass down and said, "Bob, I've got to talk to you about something. How about us being partners?" Well, bingo! We became partners and we got Stan Antolak to join us out of the residency. That was a wonderful lifelong friendship with Stan—still is. We got a partnership of three. We were overwhelmed with business and just kept growing the group until we had six.

Then, I always wanted to meld with the other group in town who, also had tooled up to about five or six urologists, all excellent people. We all got along very well. We were competitive professionally but not in any personal way. Professional competition just meant you were on the ball with responding to your doctors who sent you patients; you'd send them a letter or call them on the phone. We were no better than they and vice versa,

and I always wanted to get us together for twenty years before it happened. It never happened for twenty years, until one of the *crucial* elements of the other group retired. He was one of the finest urologists. I don't know why he felt endangered by making a bigger group, but he did. It was very curious, I thought...a wonderful guy, wonderful urologist, but couldn't make it click. At any rate, once he was gone, then the door was sort of opened, and we melded the practices. The pressures on us in private practice were the HMOs [Health Maintenance Organizations] were coming along, and they were really starting to come on line in 1990. We merged our practices in 1994. We needed to bargain rates with them. They were a 900 pound elephant, but we had to be at least ninety pounds. [laughter] So we had most all of the urologists in the east metro area, including western Wisconsin. We covered that. So we were in a pretty good position when we'd have every body together. What was even more dangerous at the time... The hospitals wanted to split us up. They wanted to make us go to only one place and be *their* urologists. None of us were interested in that. One hospital wouldn't necessarily fit everything you wanted to do. In some ways it would, but it's not the way you worked ... Surgeons travel. We were specialists who went from hospital to hospital, generally speaking. These outside forces pushed up together. The merger became inevitable, in my opinion. It wasn't because I worked for it so hard and diligently. It was the outside forces that did it. So we merged, and that has been a good story since.

DT: Primarily to be big enough to...?

RG: Now, it's a group [Metro Urology] of over twenty urologists.

DT: So that put you in a better position with the HMOs?

RG: Right, it did. At first, I wasn't interested in the *power* that a group has to do rate bargaining. [chuckles] I was interested in bringing expertise to the community. If you have a big enough group, you can start to create expertise.

For example, before the merger I branched off into pediatric urology. I took special care to relate to the University people who were doing that. Colin Markland was the first one over here at the U. He came in the late 1960s just as Doctor Creevy was leaving. Ricardo Gonzalez was over here in pediatrics. So I was always trying to relate very closely and I learned how to do some operations from Colin. So I was doing all of the pediatric urology in Saint Paul after a while, because nobody else wanted to do it, and I was fascinated with it. It was the happiest part of my practice. I just loved that part of the practice. I did the routines. If they really got out of my expertise, I quickly could see that and I'd send them over to the University. So they were happy and I was happy and so were the patients then. [chuckles] They knew they got the best.

For other specialties, we needed more than that. When my new partner, Mike Pergament, came out of the University, he was better trained than I was and knew more pediatric urology than I, so, gradually, I shifted all my pediatric practice right to Mike. As I always said, Mike was not only better trained than I was in pediatric urology, he was a lot smarter. [chuckles] So I gave him all those patients.

Also, for the other group, we got in Steve Siegel from the Cleveland Clinic who is an expert on neurogenic bladder. Well, this is what you needed to do. When you've got a big enough group, you can start doing that. We had twelve when we merged. Then, it makes it possible to start building on that. So we got a stone expert. We got this, that...and that's great.

The problem with the group, as I see it, it's mostly general urology. I don't think it's quite enough into academics yet, and I'm most anxious to try to put our department of urology and them together in some fashion or another. Now, there's a very close relationship with pediatric urology. The pediatric urologist at the University is part time in our group, and vice versa. We help cover the University service and so forth. But I'd love to see us build on that. I'd love to see much more academic get together. I hope that will be possible. I'm... Well, that's enough. Right now, it's pie in the sky, but, hopefully, it will get put together more closely than it is now. We have a wonderful big group. I think it needs that academic attachment.

The other important thing for *any* group in town...the University is of *utmost* importance. It's not only the academic leader and research leader and everything else, but that's where we get our wonderful new urologists in town. To be sure, we get them from the Mayo [Clinic] also; to be sure we get them from the University of Iowa, the Cleveland Clinic, and other places. What we need in Minnesota is a first-class place like the University, a big research center, and the Mayo is just icing on the cake. So we have a wonderful situation in Minnesota, not equal, probably, anywhere that I know of—but I don't know much the rest of the country.

DT: [chuckles]

With the introduction of Medicare and Medicaid in the mid 1960s, did that have any impact on your practice?

RG: A *tremendous* impact. Good question. Up until 1965, I remember I was still sort of struggling. You know, I was doing okay. I remember we were able to move out from our parents' homes. [chuckles] That made them very happy, I think—in retrospect, even happier than I suspect. So we had a house of our own, and we were doing okay. Then, Medicare and Medicaid came along. There were two things that were immediately observed. There was a tremendous backlog of needs in the older group. They were not coming in for a routine... "what's wrong with me?" Why am I getting up six times at night etc etc? So there was a tremendous need. My practice in 1965 just went zoom! It was obvious. The earnings I had for those years went whoosh. It was geometric. I thought it was geometric after about 1961 to 1962, but it *truly* became a geometric curve in 1965 and thereafter.

Medicaid meant that the people left the old Anker Hospital and came downtown. Why? All you had to do is talk to them. If you had an appointment at four o'clock in the afternoon at Anker, you had to get there at eight o'clock to register. Come on. That's not

how you run an efficient place. You have to be efficient for patients, and it wasn't, so they came downtown. That was not much of the practice, but it was obvious that this was a good thing for the people who were on Medicaid.

The Medicare practice pushed me into 1968 merging with Eddie Richardson (Doctor Foley's former partner) and getting Stan Antolak into the practice, and, then, growing the practice from there. It was sort of a golden age of the ability to build a practice rapidly.

DT: In the 1960s, were you making a lot of referrals back to the University physicians?

RG: Well, once you graduated, you could do almost all the things except things where you didn't feel you had expertise. For example, Doctor Creevy at the University and Doctor Ormond Culp at the Mayo were experts in hypospadias. I wasn't going to start doing hypospadias repair with two of the world's experts in Minnesota... I referred all those cases to the University. If there was a case and I couldn't figure out what to do with it, I'd always send it over to Doctor Creevy, or at least call him on the phone.

I remember I was cystoscoping a little girl three years old. This was probably around 1964 or 1965. I looked in her bladder. She had this tremendous onset of frequency, no infection. She had sterile urine and clear with nothing in it. Yet, she's going every ten minutes, suddenly and abruptly. I looked at her bladder and I didn't see anything. You know, you pull the telescope out of the cystoscope and then the water comes out and it was bloody. I looked back in. There were petechial hemorrhages all over the inside of her bladder. I'd never seen that before in a child, but it was typical of adults who have interstitial cystitis. So I called Doctor Creevy and said, "Doctor Creevy, have you ever seen a case of interstitial cystitis in a *child*?" He said, "Oh, I think so. Maybe one or two." I said, "Well, I think I've seen one." I went back and talked to the parents. All the symptoms had their acute onset when the new baby came into the house. The little girl was disenfranchised not only from her parents but from her grandparents. No longer was she the apple of all of their eyes. She had the acute onset. In my opinion, her interstitial cystitis was fundamentally of psychogenic origin. I said, "Just give her a lot of TLC [tender loving care] and she'll be okay, and she was.

Subsequently, Stan Antolak and I kept looking for interstitial cystitis in children when we had these kids with acute onset of severe problems and nothing else found. We published a paper ["Interstitial Cystitis in Children," 1970]. It's still the biggest interstitial cystitis in children's paper in world...about twenty-two cases, if I remember right. I, subsequently, found about another twenty that I never published.

That was the kind of thing. I'd always call Doctor Creevy if I had a question, or when Doctor Foley was here, if we had a big time problem. Of course, I was always [unclear] to them. The relationship to the University with the true expertise, handy and everything else, was extremely important. I always tried to keep track, go to the journal clubs, and so forth. It was a very good relationship for me personally.

DT: There's a lot of change happening in the medicine in the 1960s.

RG: Yes.

DT: It seems there was a lot of concern about manpower issues and there being a shortage of physicians, particularly family practitioners and rural physicians. Were you aware of this at the time? Did this influence you and your practice?

RG: Yes. When I got into practice and I had a house in the neighborhood, people would come and ask me who could they see for their doctor. They couldn't find one. There were no family doctors with room. They didn't have space on their schedules to see anybody new. That was true of family doctors then. I remember how difficult it was for patients to get a primary care doctor. That was in the 1960s, an interesting problem. Of course, nowadays, it's a serious problem.

The health plans came along, the HMOs basically... By the way, they all operate under one law, the 1973 HMO Act. I don't care what you call them, they're all HMOs. There are some pure indemnity insurance companies but they're rare, individual policies. At any rate, the HMOs decided that whatever primary care doctors did wasn't very important to them, so they don't pay them properly. The result is, of course, we have nobody or few going into family practice or internal medicine. It's a very bad situation brought on by... When you start to give power to corporations like that, you've performed an idiot act, and that was Congress who did that. They thought that the HMO's would ration care, because they didn't want to take away the fringe benefit of free health care insurance, the cheap health care insurance with the employer-based system. It's a tax deductible expense. It's unusual. It's only in the United States. It's actuarial idiocy and politicians are never going to repeal it, as far as I can tell. So they have to work around that to get a system that will work. Currently, they're not working in the right direction, in my opinion, but we won't go into today's politics.

DT: [chuckles] Although, a very interesting subject it is.

RG: Yes.

By the way, if you look at my curriculum vitae, it's all politics after a while.

DT: Yes.

RG: And, by the way, I did get involved in medical politics since 1973 when the HMO Act passed.

DT: Okay, good.

RG: The reason I did is I was reading the *Saint Paul Pioneer Press* one day, and I noticed there was an article about the HMO Act of 1973 for the state. It's also federal law. I remember reading that, and I said [Doctor Geist sniffs twice], "Something smells here." I sat down and started thinking about it. It took me about a week to figure out

how it would work. I went to the next meeting of the Board of Trustees of the Minnesota Medical Association [MMA], many of whom I knew, and I said, “Guys, this is really bad news. Do you know how this works?” They said, “Oh, yes, we’re backing that.” I about fell over. They said, “We’re backing it because if we don’t do it, the hospitals will get all the money, and we won’t have any control of medicine.” I said, “Now, wait a minute. You think if they give *you* the money that you are so trustworthy and wonderful, they’re going to trust you with their money rather than the hospitals? You forget the hospitals are allies with parallel interests.” They said, “Well, the really important issue here is we’re afraid that somebody is going to set our fees, not us. If we try to get together, it’s an anti-trust violation. If we form an HMO, it won’t be an anti-trust violation.” *That* was what they were looking at.

That was under the advice of their attorney who was a guy named Jule Hannaford. Jule Hannaford was an absolutely brilliant lawyer for one of the big law firms downtown. He was about the smartest lawyer I ever ran into. He beat me *every* time but once. That still burns me.

[laughter]

RG: At any rate, that was the advice. The Minnesota Medical Association has sort of been in the throes of thinking they were on the cutting edge of medicine because they backed managed care. Of course, it meant that they were on the *bleeding* edge and doctors bled bloodily because the HMOs came on and got all the money. Then they said how they were going to spend it. Primary doctors were the first to suffer. But the first ones before that were the psychiatrists. Do you want a story about that?

DT: Yes, absolutely.

RG: Do you want a story about that?

DT: Yes, sure.

RG: Well, what happened there was very interesting. There was a man who was very depressed, and he went to his family doctor and said how depressed he was. He said, “I’ll refer you to psychiatry.” So he did it. But instead of going to a psychiatrist, he was referred by one of the health Plans to a group run by a businessman/social worker. Now, who set up that for all the psychiatric care? You didn’t see a psychiatrist; you saw a social worker in group sessions. That was the guideline of referrals for this HMO. So he goes to the sessions, and he goes home and later commits suicide. Then, the wife and the two-year old become plaintiffs, and they go to court. The guy who took the case was one of the really fine plaintiff attorneys in the Minneapolis—he was a good friend of mine, by the way—a guy who sued doctors all the time from the Robbins [Robbins, Kaplan, Miller, & Ciresi] firm. His name was John Eisberg, E-i-s-b-e-r-g. At any rate, that was that.

The only thing I knew after that was that there was a little notice in the back of the *Saint Paul Dispatch* on one of the back pages in a column about an inch long. It said something about there had been a settlement of the suit, and it was for half a million bucks, which, at the time, was big dough. I said, "Wow! that's interesting. How did this happen?" Think about it for a moment. If they had to put the businessman/social worker on the witness stand, the attorney would have said, "I have only two questions for you. Would that man have committed suicide if you had referred him to a doctor who might have given him a prescription drug or put him in the hospital?" Then, the businessman would have grabbed his lapels and pontifically said, "Well, of course, he might have been better there, but he might have committed suicide there, too." It's a reasonable answer. "I only have one other question. Did you make *money* by not sending him to a doctor or do a hospitalization?" The answer is yes, because he was capitulated to take these patients. He would lose money if he referred them off to a real doc, but he made money if he didn't.

The upshot of that was very interesting. All the health Plans came through with contracts that said that the family doc or other doctor who referred a case through a referral system which went to the businessman/social worker, or where the HMO said they were supposed to go...the original doctor was responsible for the referral, *not* the health Plan. That was written into the contracts. About ninety percent of the people signed all the contracts in April of that year. The end of this case was in January. Somebody read the fine print and said, "Oh! we aren't signing this." Yet, that ended up in those contracts. It was many years later when a coalition of providers, within just the last few years, got rid of those sorts of onerous things. The blame belongs to the referral system that the HMO does to cut cost, and has nothing to do with good care.

DT: So this was in the 1970s then?

RG: No, this was probably in the 1980s. Yes.

DT: It also seemed that even before the HMOs came along that there was a problem with not enough people wanting to go into general practice or primary care.

RG: Actually, Minnesota tooled up, as you know, with a wonderful program of having a Medical School become interested in family practice, the Duluth school. They had a department here that was interested in that also. I think they did a wonderful job, because we had more family practitioners than probably anywhere else in the...I don't know if in the United States, but certainly they were relatively flush with primary care, just relatively. Numbers have gone down relative to what they were. So that's very sad, because we need them badly.

Some very interesting statistics now were published in *Health Affairs* [: *The Policy Journal of the Health Sphere*] this last January by a professor and a physician at the [University of] Pennsylvania School of Medicine...a guy by the name of Richard Cooper. He maintains that the quality in the Midwest is high because we have more doctors than in places where they have less. Furthermore, he says, "It doesn't matter what kind of

doctors,” just that they be more. Very interesting. He also says the reason we have more doctors is we *spend* more, than anywhere else, up in the northern tier of states. This is contrary to everything you read in the newspapers all the time. The reason it’s contrary is that Cooper has the facts of the spending other than from Medicare. Medicare statistics show that the southern tier of states has low quality and a high number of specialists, as they always say. The number of specialists they claim from the *Dartmouth Atlas [of Health Care]* is phony. It’s an estimate, and it’s not reality. Cooper’s numbers are real. All he says is they got less doctors down there of all sorts and we’ve got more. We spend more; they spend less, but they spend more on Medicare. The difference is they spend a lot less on the private insurance. In other words, they’re poorer. They spend less in total than we do, and we’re way ahead of the quality game. You don’t think that from what you read in the newspapers about how we’re so much better than they are. We’re not that much better. The doctors down there are no different than the doctors up here. Training in the U.S. medical schools is superb everywhere. They’ve got excellent doctors, machines, equipment, everything everywhere. It’s just that they’re too few of them down there, and the total expenditures down there are less on the populace. That’s the difference. Interesting, isn’t it?

DT: Right.

RG: That’s not guiding public policy. What’s guiding public policy is incorrect extrapolations of the Medicare only statistics from the *Dartmouth Atlas*. By the way, the statistics are perfectly accurate; it’s just the interpretation is the problem. Well, enough of my baloney here.

DT: [chuckles] No, this is very interesting...

RG: It is.

DT: ...particularly given the contemporary debates right now.

You had mentioned the Minnesota Medical Association. Were you affiliated with any other professional associations in the 1960s and 1970s?

RG: Yes, I’ve got a whole list in my curriculum vitae.

DT: Okay.

RG: I even joined the National Pediatric Urology Association, or whatever it was called at the time. I used to have a wall of diplomas and memberships. So, yes, I did quite a bit and was very much involved in the Twin Cities and, then, the Minnesota Urology Association to the present. Those were great years. I enjoyed them.

I must say this. One thing I resented when I was in practice was the amount of time I spent on the politics. I remember when they first asked me if I wanted to be the president of the Ramsey Medical Society and later the United Hospital staff. I said to my wife,

“Gee, I’m not so sure I really want to do that. It will just take too much time.” She said, “Will you be happier if you’re not doing anything actively in this realm or do you think there are things that have to be done? Or will you ulcerate if you’re not doing them?” I said, “I’ll ulcerate without.” Anyway, I stayed politically involved. At the time, I resented the time I spent going to MMA meetings arguing with people who I loved individually but who I disagreed with strongly.

The end result of all that was *very* interesting. When I retired, I looked back, and I said, “Some of my closest friends are the people I would argue with the hardest.”

DT: [laughter]

RG: I also had a lot of interesting things, like people coming to me from the old trustees of the MMA. They’d come and say, “I wish we’d listened to you.” They had stubbed their toes, and some of them were ready to admit it. I was very gratified. I found out so many of the good people I just really had such great respect for became good friends, even though we were *diametrically* opposed on some issues. It made a difference.

I always try to teach the young people coming up in the medical politics now—God knows we need them badly—that the other guy always believes what they say. They’re not being malicious or self serving. They’re being honest about what they feel is right. They don’t have ulterior motives. They’re not evil. They’re just like you, and they think what they think is right, and you think what you think is right. Today, they are the idea you oppose. Tomorrow, they may be your ally. Always look at your opposition as your ally, and always remember to respect their opinions. You don’t make an *ad hominem* argument that they’re a bad person or something like that. That’s not the way it is. There are a few bad people out there, but you won’t find many of them in medical politics, *very rare*. I can’t remember one off hand. We had a couple bad doctors that every once in a while you’d run into. They were doing their best, but they weren’t very good. There are, maybe, one or two that are dishonest that I can think of. In medical politics, I’ve found nothing but people who are absolutely straight, upright guys who I just might have differed with in opinions. I always try to teach the young people coming up in politics that you have to respect the opinions of the others. So that’s been helpful.

DT: In the 1960s, it seems there were some quite contentious politics among Saint Paul physicians towards the University. I’m thinking in particular of the efforts to get a second medical school in the Twin Cities.

RG: Yes, I was part of that movement, by the way. When I came on board, the antagonism had started *many* years before. If you want to go back to 1915, at that time, the new dean of the Medical School was a physiologist from Chicago, not an M.D. He was the new dean, and he was dean until about 1940 something, a beloved figure who built the Medical School and the faculty who trained me. They were at the end of their careers when I got here. Why can’t I click on the dean’s name, the most famous...?

DT: Was it Elias Lyons? Was that his name?

RG: Yes. He built the Medical School by having full time faculty.

For example, my Uncle Emil Geist was the *only* orthopedic surgeon besides Doctor [Arthur] Gillette in the Twin Cities. He was very instrumental in the department here at the University and a very close friend of Doctor Wallace Cole, who, later, became the chair of the Department of Orthopedic Surgery. My Uncle Emil was very instrumental in helping get this Medical School... Instead of having a faculty kind of come itinerantly from downtown, the private doctor sort of thing, he was helpful in moving the Medical School into a full time faculty, which is exactly what it needed. Well, that was resented. Accusations were that he [the full-time faculty physician] had free office space. You know, you could hear the arguments from downtown. "What are they doing, they get free patients from everywhere?" Okay.

So all of that had gone on well before I got here. By the time I came out of Medical School, I do not sense there was that antagonism. There really was not.

In the 1960s the problem was was everybody saw we had a *lack* of doctors and the University wanted to tool up for another 100 people. Maybe it would be better to start a new med school. So in Saint Paul, Doctor Davitt Felder decided he ought to look into getting a new medical school. They hired a guy out of the MMA named John...what's-his-name. He was to help build the infrastructure to go into it. That was a great threat at the University, I'm sure. At the time, I was just starting out in town, and I just helped Davitt because he was a surgeon in town. I didn't appreciate, I don't think, the politics of it. So, happily, I was never in any crossfire at all. Davitt probably was. That died because the University was totally opposed, probably for good reasons. Happily, as I say, I had very little to do with it, except, there I was trying to help Davitt get things rolling and it never did.

DT: You don't remember the last name of John?

RG: I can't remember John's last name.

DT: [chuckles]

RG: He was a nice guy.

DT: In reading the archival records around this, one of the things that Davitt Felder's group seemed to be saying was that the University was producing too many specialists. This of course ties in with the shortage of general practitioners.

RG: I don't remember him specifically talking about it. He might have. As I say, I was on the periphery. I suppose that was another argument for another med school. I just can't remember the timing of the Duluth school.

DT: That was 1972.

RG: See, that would be a response probably through the 1960s when a second medical school was thought to be necessary.

DT: Yes.

RG: If I remember right, I think there was impetus nationally for more medical schools.

DT: Yes, certainly. It struck me that the efforts of Davitt Felder began maybe in like 1960 and continued through the 1960s. In the late 1960s, there was this recognition that a second school was needed, but instead of looking to Saint Paul, the attention was on Duluth, or Rochester. The Mayo was trying to start a medical school, too.

RG: Yes. You probably know a lot more about the history than I do.

DT: [chuckles]

RG: That's your area of expertise.

DT: Well, I have the archival side...

RG: Oh, yes, sure.

DT: ...but one of the reasons I wanted to talk to you is because I was curious if you were involved in that. You said you were, so that's great.

RG: Maybe I had a personality or something... I remember John, the guy that Davitt brought up to raise money for a new medical school, the kind of guy you'd send in to the CEO [chief executive officer]. That's where you had to get a grant, okay? I remember John showed me his secret list of the doctors he thought would be of help in Saint Paul. He said, "You'll notice you have five stars and nobody else does."

DT: [laughter]

RG: I said, "Gee, John, thanks. I don't know if I deserve that!"

[laughter]

RG: I thought that was really funny. That kind of thing sticks with you. It's our ego. [laughter] A real joke, though. Yes, I know not much about that and the timing either. So I'm a little fuzzy on that.

DT: Another thing that was happening related to family practice was the Minnesota Academy of General Practice seemed to be quite frustrated with the University and was instrumental in getting the Department of Family Practice established, but they weren't

happy with how the Family Practice Department was being run. Herb Huffington, in particular, had some choice words to say about this.

RG: Who was this?

DT: Herb Huffington.

RG: The name is familiar, but I don't know him.

DT: So you don't recall anything about the Academy of General Practice?

RG: I really don't or their antagonism. I remember we had a residency program both at Miller and at Bethesda. They were independent. Ummm... Hmmm. Yes, I don't recall much. I knew the guy... The first who ran the program over here was... What was his name? Do you remember his name?

DT: I do, and, now, I'm blanking. Benjamin Fuller?

RG: Well, Ben was. He came from Saint Paul. He joined the faculty. There was somebody else who was in charge. Ben was a close friend, by the way.

By the way, the Fuller/Magraw lecture is tonight...

DT: Oh. Oh, wow.

RG: ...at six o'clock or seven. I don't think I'm going to be able to get there. Ben Fuller's family gave a grant with Dick Magraw's family.

In any event, the current chair is one of our residents from Bethesda Hospital, Mac [Macaran] Baird. Of course, a better guy you'll never find in your life, wonderful, wonderful kid.

We also graduated another Bethesda graduate from family practice. His name is John Sutherland who became a professor of family practice at the University of Illinois in Springfield. The interesting thing about that school... Are you familiar with a man named Doctor Dick Magraw?

DT: I interviewed him.

RG: Oh, well, I don't know if you know *all* about him.

DT: [chuckles]

RG: Dick is the one who started three medical schools for the State of Illinois. Springfield was one of them, and, of course, John Sutherland... It's a small world, you see.

DT: Absolutely, yes.

RG: Yes, it's a small world.

DT: He's wonderful. I really enjoyed him.

RG: He's a very close personal friend. He's a different generation. He's my sister's generation. They were in grade school together. He was one of the professors when I was in medical school. I didn't know him. I, subsequently, got to know him because we were in the same senior Boy Scout Club, as a matter of fact. He was a different generation, so I didn't know him there. Later, I only got to know him, and I only really got to know him very closely and personally since about 1999 or 2000 for a variety of reasons outside of medicine, but, also, in medicine. At any rate, he's a wonderful, wonderful man, one of the great men I've ever known.

DT: Yes, I really enjoyed him immensely. He's very interesting.

RG: You should have spent more time with him and less with me.

DT: Oh...

[laughter]

DT: Although, I would love to spend more time with him. That's for sure.

One of the things that I noticed is it seems to me that the Minneapolis private practitioners seemed to be quite different to the Saint Paul practitioners. The Minneapolis physicians' seemed to be less... Well, you've expressed there wasn't so much antagonism between practitioners and the U, necessarily, but it certainly seemed that if there was any antagonism, it was more on the Saint Paul physicians. Did you notice any difference?

RG: Let me tell you some interesting things. When I came to practice in 1960, Minneapolis was known as the fee splitting capital of the world, and we had *none* in Saint Paul. Very interesting. Also, in Minneapolis, the antagonism between practices was high. In Saint Paul, I never saw that, because the people who might have been antagonistic were at different hospitals. The hospitals might have been antagonistic...the we're better than they are kind of baloney. I went to all of them, and, of course, I saw that they were all fine. [chuckles] It was funny. The hospitals might have been antagonistic and rivalrous.

Of course, they all ended up merging because of the economics of it. Minneapolis reverted into something other than fee splitting.

I remember when I went into practice, I talked to George Garske in Minneapolis. I was interested maybe in joining their practice and vice versa. I did not. I remember talking to him. He said when he came into practice, every time he had one referral, the guy then would ask him for a kickback, split the fees. He said, "I'd never do that. I built my practice without doing that." But it was tough, at first because it was total fee splitting, which is a very vicious practice, by the way, as you can probably appreciate.

DT: Yes.

RG: Great threat to patients. That was starting to go down when I came into practice in 1960, but at least the reputation over there was it was the capital of fee splitting in the United States. Saint Paul was absolutely clean. *Nobody* ever asked me for a split fee, and I went to all the hospitals to start with. That just wasn't done over there, a very interesting difference.

As far as the antagonism to the U is concerned more one place than the other, I maybe can only speak for urology. It was 100 percent antagonism after Doctor Creevy left. [chuckles] That was very sad. Elwin Fraley came in, a very fine urologist. He created one of the really fine programs. He graduated more professors of urology around the United States than Doctor Creevy ever did. Yet, his personality was such that he immediately antagonized everybody the day he walked in the door. I won't say how, but he did. He antagonized Doctor Creevy in one form or another. I can't remember what the exactly happened. At any rate, he couldn't win after that. It came down to there were only two urologists in town who kept on a friendly basis with him. It was me and my partner, Mike Pergament. Mike had trained under him. Even with other people who had trained under, he was antagonistic. He, then, started the outreach program going out of town, which might have been a referral base for somebody else in town. So everybody hated him for *that*. I mean, he couldn't win.

DT: [chuckles]

RG: He was a different personality, and I can see how people would not get along with him. I have a diagnosis for him, but we won't go into that. I will say this... I remember I'd talk to him on the phone frequently. I always wanted to keep in touch. I remember one time he was telling me about an episode, and I was on the phone for half an hour. I was laughing till I almost fell out of my chair, it was so funny. He had a great sense of humor, which nobody ever appreciated. He was just a scowling *meister* to too many people, but, actually, he was fun. In any event, poor Elwin couldn't win. He was here for many years, graduated many wonderful professors and urologists. He had a great urology program. But, you know, that's what happened. That alienated the downtown in urology, but the alienation of other sectors, I'm not as familiar with.

I must say, another thing in urology there's a lot less of us than there are orthopedic surgeons, but we have a Twin City Urologic, which became the Minnesota Urologic Society. Everybody, the Dakotas, everybody is friends. That's not the way it is in orthopedics, as far as I understand. Maybe they're chummy now.

[laughter]

RG: We seem to have a good thing on that; they don't seem to have as such a good thing, as far as I understand. I might be wrong on that. I don't know.

DT: From my sense of reading the archival material, it certainly seems that the politics of referral was maybe somewhat of an issue and the fact that Minneapolis had this fee splitting system. It would make sense...

RG: That's been gone since the 1960s. I think that was straightened out after that. You know, if you got caught doing that with the federal programs—they came in 1965—when they're in and if you're doing any of that, they're going to hang you. It was \$25,000 per offense and five years in prison and five years out of Medicare forever, or something...

DT: Yes, it's pretty steep.

RG: ...if you were splitting fees.

I used to go once a month to a western Wisconsin town, which will remain nameless here. By the way, a very fine clinic and hospital, and I was happy there. But they got in sort of a problem of overhead, you know. Clinics, they don't know quite how to be efficient often, so they get too many ancillary help, which they probably don't need. So they were having problems. The doctor who was designated to come talk to me about putting my name on the door, and, of course, we'll do the billing for you. It was a fee splitting operation. I said, "Well, that's fine. I'll tell you what the fines were for the ten patients I saw this morning. That's a \$250,000 fine. You won't get any patients from Medicare for five years. That's reality. Do you want to talk any further about this?" I never heard another word. That was the *only* time I had that happen. That was a common practice to have a specialist put their name on the door and do their billing. They would do the billing. They would collect the fee, but they'd take out for administrative fees about half of it, maybe. That's the way the system would work. Well, we didn't need that business, and we just said, "Somebody else might want that but we don't do that." So I never had any problems after that. That's the only time somebody tried to split fees with me. Very interesting, isn't it?

DT: Yes, that's incredible.

RG: Yes, very interesting. When I told him he had \$250,000 in fines from that morning, that shut him up.

[laughter]

DT: I'm sure.

When you were working with Davitt Felder, do you recall anything about his interactions with the State Legislature or the regents?

RG: No, I don't know. He might have had a lot and I wouldn't even know about it. He is now ninety-four.

DT: Oh, he's still around?

RG: He's bright as a tack.

DT: Ohhh.

RG: I see him about once a week in the fall.

DT: Wow, well...

RG: I could have seen him this morning if I'd gone to a meeting that we both go to once a week for about nine fall Wednesdays, but I didn't feel like going this morning for a variety of reasons. It was a topic I wasn't interested in. He's just as bright as a tack. He looks just as healthy as a sixty-year-old.

It's just incredible.

DT: I'd love to get in contact with him.

RG: Oh, be sure to call him because he's around. He's in the phone book, I'm sure.

DT: Okay.

RG: If he's not, let me know, and I can find out.

DT: Excellent. That would be great.

RG: I could find out.

DT: Fantastic.

In the late 1960s, the University expanded the Health Sciences and expanded the number of medical students and what not.

RG: Yes.

DT: How did that affect you, if at all?

RG: It didn't really. Relationships were strictly with the Department of Urology, so it had really had no affect on us in private practice. I always kept in close contact but, as I

say, Mike Pergament and I kept that contact. We thought it was extremely important for our practice, for our community. So we made sure we stayed friends with Elwin Fraley.

By the way, I just have such great admiration for so many of the guys that came out of here. Paul Lange went to the University of Washington. Art Smith, the world's great endourologist, went to New York. Tom Hakala went to the University of Pittsburgh. Tom was never a close friend of mine, but the others were. Ralph Clayman, one of the really, truly great guys, went to, I think, Washington University in Saint Louis [Missouri]. Bill DeWolf [Boston, Massachusetts], Curt [Sheldon] [Cincinnati, Ohio]...all these guys went out from Minnesota. So this place contributed tremendously to urology in the United States. And Dick Williams at the University of Iowa. Dick is dying of cancer of the lung, extremely sick. I tried to hire Dick out of the University, but it was obvious he was going to go academic. He turned me down.

[chuckles]

DT: From your sense, private practices in general were supportive of the expansion then, at least from what you could tell?

RG: I wasn't there. If I would have had an opinion, it would have been yes, but I was never asked. I had nothing to do with it. I'm happy somebody did.

DT: Did you ever have any connection or experience with any of the Medical School deans, such as Bob Howard in the 1960s and Neil Gault?

RG: Which ones?

DT: Robert Howard?

RG: Yes, I knew Bob Howard. He's a little older than I am. He was the dean, and I would see him at an event such as the Minnesota Academy of Medicine or something. Other than that, no, I didn't have any relationship with the deans.

The dean when I was there was...

DT: Harold Diehl.

RG: Of course, the Diehl [Hall] that we're in.

DT: [chuckles]

RG: The closest to him I was his daughter married a guy I played tennis with, who was a psychiatrist in Saint Paul. [laughter]

The other one was, of course, "Dean" Smith. Are you familiar with "Dean" Smith?

She was the secretary who ran the desk in the dean's office. We called her Dean Smith.

DT: [laughter] That's good.

RG: She ran the place. I don't know if Doctor Diehl ever really did. He might have thought he did.

[laughter]

RG: She was hell on wheels. She was named Dean Smith.

DT: I guess my final couple of questions are really... In your career as a practitioner, did you observe any changes in medical practice and medical culture at the Medical School during that time, based on the residents that you were seeing, for example, anything that changed significantly?

RG: Yes. I think one thing... When I started practice, I remember Doctor John Moe, the orthopedic surgeon who ran Gillette Hospital, a famous name—that's the trouble with getting old—an absolutely wonderful man. He wanted to start up a urology service at Gillette because the kids with spinal deformities had a very high incidence of urologic birth defects. So he wanted to start that up. Somehow, I got asked to do that. I approached Doctor Creevy, and he said, "Fine." So he's the one who arranged the resident from Anker Hospital to come to Gillette. So I sort of ran that program. Then, it became much more than I could... I was so busy, I couldn't see straight.

Happily, a guy named Alec Cass came to town, an Australian. He was on the faculty, and I got Alec to take over the program, which he built up into a really fine program. It was thanks to Alec then that the Gillette was moved into...or one of the stimulus that moved Gillette into what became Saint Paul Ramsey [Hospital] when it was built. I kind of helped with that, but it was mostly Alec that got that done. Anyway, when I got Alec to do that program, that was the best thing that ever happened to me. I could do the work I was doing. I didn't think I was very good at what I was doing out there, relatively speaking. They needed more than I could give. So he developed a good program out there.

DT: Was that the early 1960s?

RG: Alec came to town... [sigh] I wrote a paper with him. I wrote a paper with Don Ferguson, our senior resident there. Boy, I'm going to have to look up the dates. Let's say it was plus or minus 1970.

Then, the other thing was Doctor Fraley didn't have a lot of pediatrics or enough, so he would send a resident down to Children's Hospital.

I remember that's where I met Kevin Zhang, Z-h-a-n-g. I'm standing there operating doing a re-implantation of the ureters, and Doctor Zhang was standing there helping me

out, telling me what a terrific job I'm doing. I said, "Zhang..." He renamed himself later as Kevin Zhang. I said, "Zhang, do you have family in China?" He was from Tsingtao. I said, "Gee, what's that famous for?" He said, "Well, Tsingtao beer." As a matter of fact, some German went to China and started the Tsingtao Brewery.

DT: Wow.

RG: It is a good beer. I said, "Zhang, are there a lot of people named Zhang in China?" He said, "Half people in China named Zhang." [mimicking the pronunciation as the Chinese would].

DT: [laughter]

RG: At the time, he had just come over. He was three months in the United States, so I'm mimicking how he sounded then. Now, of course, he speaks English like you and I do. He and his wife, Anna, are close friends, and their kids. My first meeting with Dr. Zhang, that was probably in the 1980s when I was still doing pediatric urology, the early 1980s.

So, yes, we would get residents coming over. Since I've left the practice, there's a lot more residents coming over in pediatric urology to Mike Pergament. They come over to be with Mike six months. Steve Siegel, who is really a nationally-known guy in neurogenic bladder disease, works with the residents. By the way, one person who came from the University as a resident, graduated, went over and practiced with Steve for two years is now back at the University. He's a world leader, by the way. Yes, there's that connection.

There's always something that comes up, which I won't go into in this case, in the last year which made people a little anxious about the relationship. Anyway, the relationship absolutely *must* go and *must* be built. As far as our practice is concerned, I just hope that they keep efforts going, and I'm sure for the University, they have an equal interest to do closer affiliation in some manner. So I'm hoping for that.

DT: Excellent.

My final question is can you suggest anyone else in private practice in the community whom I might speak to?

RG: Okay... Davitt Felder, or course, who we talked about. [pause] In orthopedics, it would be Rollie [Roland] Birkebak, maybe.

DT: How do you spell his name?

RG: B-i-r-k-e-b-a-k. Roland Birkebak and he's around. His wife died some years ago. He's retired. He was part of the interviewing of undergraduates for Medical School. He was a success at that. I spent one year and they kicked me out.

[laughter]

RG: I had a total of four people I interviewed and each one was better than the next. Three of them were women. The first one was a guy, and I thought he was really pretty terrific. But in retrospect, I gave all a 4+ rating. I didn't want to say any one of them wasn't superb, so I said each one of them was superb.

Excuse me just a moment.

[Dr. Geist gets a phone call. Break in the interview]

RG: That was my son.

DT: Oh.

RG: He's in town for business.

He's a partner in a small biotech company that develops and furnishes biotech research labs. It's an interesting kind of niche business.

DT: Yes, absolutely.

RG: Not only does he relate to medical, which is his biggest part, but, also, to seed companies who need the PCR [Polymerase Chain Reaction] techniques that they have.

DT: Sure.

RG: He was here for a seed company, not the Medical School. He was at the Medical School this morning. We might have connected for lunch, but he was busy until late in the day.

What was the last question you asked? Somebody else... Birkebak.

DT: Yes.

RG: [pause] Can I think about that?

DT: Yes.

RG: I'm just not clicking on somebody to come up with real quick.

DT: If you think of anyone, then...

RG: Would you want somebody of retired age?

DT: Primarily, right now, I'm focusing on the 1960s and 1970s, so someone who was around in that time.

RG: Okay, sure. All right.

DT: Especially anyone who was had relations with you and was involved in politics a little bit.

RG: All right. Well, Mac Baird. Absolutely, Mac Baird. You'll find him the most terrific person that I ran into in many years.

DT: [chuckles]

RG: For right now, we'll leave it with Rollie and Mac.

DT: Yes, great.

RG: Is that okay?

DT: Yes, fantastic.

RG: I love nothing better than talking, so it was great to be here! [chuckles]

DT: It was great chatting with you! Thank you for the time.

RG: Yes, well, my time is you time anytime.

[End of the Interview]

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