

Richard M. Magraw, MD
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

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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

Richard Magraw was born in Minneapolis, Minnesota, on October 2, 1919. He attended the University of Minnesota and received his BS in 1939 and his MD in 1944. He did his internship at Anker Hospital in St. Paul (1943) and his surgical (1944), psychiatry (1947-49), and medicine (1949-50) residencies in Minneapolis. He went into private practice at a clinic in Two Harbors from 1944-47. He joined the UMN faculty in 1950. He worked as an Instructor (1950-52), Assistant Professor (1952-57), Associate Professor (1957-65), and Professor (1965-1968) in the Departments of Psychiatry, Neurology, and Internal Medicine. He also was Assistant Dean of the College of Medical Sciences (1959-60), Director of the new Comprehensive Clinic Program in the Medical School (1960-67). From fall 1967 to spring 1968, he took a leave of absence from UMN and worked in Washington, DC, first as Assistant Director of the Bureau of Medical Services and then as Deputy Assistant Secretary for Health Manpower, Department of Health, Education, and Welfare. He never returned to UMN and after his government service ended, he served as Dean of the University of Illinois Medical School (1969-73), President of Eastern Virginia Medical School (1973-78), chair of the American Medical Association's Committee of Undergraduate Education (1970-76), consultant for the Indian Health Service (1978-80), and served as the chief of medicine at the VA Hospital in Minneapolis (1980-92). In 1992, he retired but went back to teach at the UMN from 1992-97. He wrote *Ferment in Medicine: A Study of the Essence of Medical Practice and of Its New Dilemmas* (Philadelphia: W.B. Saunders Co., 1966), which was published in 1966.

Interview Abstract

Richard Magraw begins with his background and education. He describes his residencies and his work history and discusses his work as assistant dean at UMN. He discusses the effect of National Institutes of Health research funding on medical education in the late 1940s and 1950s, the focus on specialization and the de-emphasis of primary care during this time. He goes on to discuss the faculty practice issue at UMN in the 1960s, the regional and national concern in the 1960s over a shortage of physicians, the national trend in the 1960s of regional health planning, the development of family practice as a specialty, his book *Ferment in Medicine*, and the influence on medicine of the introduction of Medicare and Medicaid in the mid- and late-1960s. He discusses the Comprehensive Clinic Program (1960-67), the relationship between the Medical School and Minnesota state legislature, the reorganization and expansion of the health sciences in the 1960s, the relationship between the Medical School and the affiliated hospitals, and the relationship among the Schools of Nursing, Medicine, and Public Health within the College of Medical Sciences. He describes the attempt to establish a medical school in St. Paul, the establishment of the Department of Family Practice and Community Health, and the separation of the departments of Psychiatry and Neurology at UMN. He discusses what he did after he left the UMN, including his work in Washington, DC.

Interview with Richard M. Magraw

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed on July 31, 2009

Richard Magraw - RM
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I am interviewing Doctor Richard M. Magraw at 5256 Ashlar Drive, Bloomington, Minnesota. The date is July 31, 2009.

Thank you, Doctor Magraw, for agreeing to be interviewed. Why don't we start? If you would, give me a little bit of background about where you were born and raised for example, and where you did your medical training.

RM: I'm strictly Minnesota. I was born, actually, in a Minneapolis hospital, but raised in Saint Paul. Interestingly, a part of my family homesteaded where the University of Minnesota is. I attended the schools in Saint Paul and, then, the University of Minnesota, undergraduate, and, then, Medical School, graduating in March of 1943.

I had an internship at Anker Hospital in Saint Paul and surgical residency that began in Minneapolis and, then, I continued as a preceptee in Two Harbors, Minnesota, where I joined, on the day it started, a prepaid medical plan. That experience, since there were no doctors north of us in small-town practice, really taught me what the medical profession was; although, I would not have said this at the time, it set the stage for everything else I did.

I, then, had a rather complex educational history, since I returned to the University and took training in psychiatry and in neurology and, then, started in internal medicine. That was interrupted by going to the Korean Conflict. I returned from that in 1955, and resumed work at the University and continued there, becoming, ultimately, a full professor in both Internal Medicine and Psychiatry. I was an assistant dean for a period, but, mostly, I worked as director of the clinics. The University Hospital, at that time, was a charity hospital for the state. Every county had, by law, a special fund for sending patients to the University Hospital. So we had a vast supply of patients, particularly during the Depression; although, we, at no time could rival the Mayo Clinic for numbers of patients, we still had vast flow of patients. That's the background that I had with the University.

DT: First, of all, why did you get into medicine?

RM: Like many people, when I went to the University, I had one set of ideas; I was going to teach math. But, then, when I felt that wasn't really the most interesting thing to do, I debated in my mind whether I should go into geology or medicine. I got caught up in the competition of getting into Medical School. Medical School, in those days, was highly demanding in the sense that, although we were admitted to Medical School, we were immediately confronted with the fact that one could readily flunk out of Medical School. The drive to succeed was such that most of us never looked back.

DT: How is it that you began in surgery? What prompted you to change track and move to psychiatry and medicine?

RM: I went to this prepaid plan in Two Harbors, since the day it was starting. It was a *marvelous* experience. One of my main partners had been a superb physician and surgeon, Everts Graham's first assistant. Nonetheless, what we did was surgically oriented general practice, and I became increasingly aware of the role of caring for patients rather than focusing on the procedures of medicine. I left Two Harbors, in January of 1947.

At the end of World War II, psychiatry was, I think, the most prestigious specialty at the time. People who weren't in medicine, at that time, I think had no picture of how little we understood about psychology and psychiatry in any formal sort of a way. The psychological casualties of World War II really enlightened the entire country about the importance of that, and certainly enlightened me. So I came back to the University. I was going to take a year of psychiatry and a year of pediatrics, things that I needed, that I found in practice that I was deficient in. By that time, I'd decided I wouldn't stay in just surgery. I was interested in taking care of people. But when I got into psychiatry to take a year of it, why it became clear that things were changing in medicine and that you almost had to be a specialist or you would be a second-rate doc [doctor]. So I proceeded through psychiatry but I didn't want to just do psychiatry and that's why I wound up taking internal medicine training as well.

DT: That's a lot of training. [chuckles]

RM: It was a lot of training. It was a wonderful way to practice medicine.

DT: It seems that you're quite unusual in that regard. I've never met another physician who had done such extensive training in so many different specialties.

RM: Well, it had to do with my view about what was going on in medical education. I think it was Eleanor Roosevelt that said that life must be lived in prospect, but it can be only understood in retrospect. I've been thinking of that phrase ever since you called or you wrote and said that you'd like to talk to me about the history of the University of

Minnesota Medical School. Looking back, I understand quite differently, and I think quite clearly, what was going on.

DT: Excellent, this is what I want to hear about. [chuckles]

RM: Well, I'll be discursive about this. I'll just talk and it won't be entirely sequential or lucid.

Huge things were happening in medicine in the mid and latter 1940s and, then, on into the 1950s. I can best explain that by speaking about the effect that the National Institutes of Health's [NIH] research funding was having on medical education. There were two women—oh, dear—Mary [correctly Florence] Mahoney and [Mary] Lasker... What was her first name? Both of these were wealthy women, and they kind of took a hold of the Federal legislative and administrative process. They were very skilled at this. Darn it, I wish I could think of Mrs. Lasker's first name. [chuckles] It will come to me. Anyway, they seized on the National Institutes of Health, which was in existence, and worked with Congress to get it funded. From 1947, I believe, for twenty-five years, thanks to the effectiveness of these women, Congress increased the funding of the National Institutes of Health at twenty-five percent per year. Think about compound interest...twenty-five percent increase for twenty-five years. It was an enormous flow of money. It was going to the National Institutes of Health, but it was basically meant to be dispersed to the medical schools. In the process, medical schools were changed from institutions for teaching doctors to research institutes. That's very clear in retrospect, but I don't think it was clear in prospect.

I once gave a lecture at a medical society in Grand Rapids, Michigan. It was a situation in which I remembered a limerick in time to, I felt, save the lectureship, because I'd been given a very grudging introduction...

DT: [chuckles]

RM: ...to this annual meeting at the Kent County Medical Society. The limerick I remembered was,

“There was a young lady from Kent
Who said that she knew what it meant
When men took her to dine,
Gave her cocktails and wine.
She knew what it meant, but she went.”

The reason I remember that limerick joyfully was because that was precisely what I was going to talk about, which was what was happening to medical schools in the funding from the NIH. This was entirely analogous to that. What was happening in the medical schools was that they were expanding along a course of highly specialized lines with their research funds coming in and, in effect, buying the individual faculty members to fund their research and to shape their directions in highly refined and irresistible ways. This is what was happening.

You'll understand from my background I was kind of globally involved, but, even more, I had a mission that I, then, can more clearly articulate in retrospect. It had to do with teaching medical students to take care of patients, what we would now call primary care.

[break in the interview as Doctor Magraw takes a telephone call]

RM: Let me catch up, now. Where was I? [pause]

I was *not* caught up in this subspecialty, research kind of thing where the money was. I was having such a good time as director of the clinics and seeing all these patients coming in, this great unwashed was coming in, and I felt really so very competent. Largely because of psychiatric training, I was really tuned into what people were saying and medical diagnosis was endlessly thrilling to me. I could never understand these doctors that said that they found medical practice boring. It just never was for me; they were always interesting stories, to say nothing of the diagnostic pearls that you could pluck out.

So I was a real enthusiast about something that, now in retrospect I can see very clearly, was losing its appeal to my very fine colleagues who tended to look past the human being to focus on their particular organ of interest: cardiac, bone marrow, liver, what have you. In one way, I was out of step with my colleagues in not having a pet gilet that I was focusing on. I don't mean to sound disdainful of my colleagues, because I wasn't. I thought these were wonderful fellows and gals. But as it developed, I was swimming upstream.

That became very clear when the Comprehensive Clinic Program was developed. The reason that was developed... I don't know, did Bob Howard talk to you about this?

DT: No. I actually would like to know what was the impetus behind it.

RM: Yes. Bob had asked one particular internist to take a hand at reorganizing the curriculum. That was Doctor James Carey. He was my particular friend, and I think he was the smartest guy in Internal Medicine. Cecil Watson, then the chairman, had fingered him as the person who should succeed him. Jim, later, suicided. It took me years to recover from that. Anyway, Jim was given this assignment, and he came up with the idea. He had a clearer picture of what I was doing than I did myself. So he came up with this idea of dividing the senior year into two halves. One half was patient care in the Comprehensive Clinic. The term Comprehensive Clinic meant that it was to cover the waterfront. The students were assigned green patients, fresh patients, as they came in in Internal Medicine and Pediatrics. There were two sharply divided clinics on an age basis. Then, in addition to that work, which involved picking up the patient as they came and becoming the patient's doctor and taking the patient around to the various specialties as need be, and summarizing the whole thing, students had always approximately a three-week subspecialty rotation in which they studied dermatology or neurosurgery or orthopedics or ophthalmology or otolaryngology or what have you. That's, again, a part of where the term Comprehensive Clinic came.

Comprehensive Clinic started in 1960 and it was given the gate in 1967. The reason it was given the gate was not because it wasn't successful. Students were learning and many of them, to this day, feel very warmly about that. But, it was swimming against the current as far as what I, in a downplaying way call the gible approach of the various specialties that wanted more time and thought this was sort of a waste of student time. Another thing that was happening was that our number of referrals for the University was gradually declining; although, we still had enough to function. People weren't storming the gates as they had been in the Depression Era.

I think that's an issue that remains in medical education to this day and in medical practice. You know, people in this time of considering restructuring of medical care in this country are thinking of the cost of it, but if you look behind the cost to the actualities of structure in medical care, we are almost unable to move to a patient-oriented care because we have not adequate primary care physicians. And we really don't have a medical educational system that can produce them, in my view.

[break in the interview]

RM: I've kind of jumped the gun here in talking about a point of view about medical education that really sums my whole experience up.

Let me go back to the beginning and say that I started training at the University in psychiatry with the idea of taking just a year. Doctor Donald Hastings was kind enough to take me on as a resident the first of March of 1947. That was an irregular time to start in residency, and it was an irregular idea that I had of taking just a year, but he was welcoming of this. So I continued. As I got into psychiatry and neurology—I had an extra six months, so I had a total year of neurology—I thought I really don't want to get this far away from taking care of general patients. I increasingly thought about could I take some training now in internal medicine? The Chairman of Medicine, Cecil Watson, was kind enough to concur in that, so I took a year, and that was maybe the most satisfying training experience certainly that I had in my life, because I found that I could really take what I learned and apply it in the care of patients and that medical diagnosis and treatment had become like shooting fish in a barrel. I mean, it was *infinitely* easier than it had been.

Then came the Korean War. I had been discharged from the service in World War II when I was called up to active duty, because of an innocuous disability. Doctors were the only thing drafted in the Korean War, so I was drafted and I went to Korea and Japan for two years and returned and picked up my function in the Medical Clinic as the assistant director, and, then, worked with Carlton Chapman, who was then the director. Then, when he left and Eddie Flink left, why I was made director of the clinics. I don't remember what my academic rank was at that time. I think it might have been associate professor of Psychiatry and Medicine. Ultimately, I was made full professor, which was really quite a unique thing.

In that time, Bob Howard asked me to serve half time as assistant dean. I had that experience, but my heart was really in the clinic, so when the Comprehensive Clinic was established, I was made head of that.

DT: What were your responsibilities as assistant dean?

RM: There were some administrative and chairing functions for committees and things, but, largely, it was a matter of dealing with students and applicants. I don't mean to slight the administrative functions, because there was always a fair amount of liaison with various official functions having to do with curriculum and private practice.

I want to say a word about Doctor Howard, because I think he never really got his due for coping with medical education in this time of change. I want to go back to that aphorism that I started with. It always has to be lived in prospect, but comes to be understood in retrospect. I don't think *anybody* in medical education would have had as clear a picture of what I now see as having happened. The whole thing was really radically changed, and we became, instead of producing the professional product of a physician, we became sort of the first half of medical education, because the students then made a choice at the end of their medical school as to what kind of a doctor they would become. Instead of having, essentially, a unified product and unified profession, we became a whole series of things. I think one of the medical societies here in Minnesota has as its motto, "First, a doctor." But, of course, that's a losing game, because these fellows are first an orthopedist or first a neurosurgeon. That's where their loyalty is.

I'm given to aphorisms. Did I quote you Leon Blum, the French premier...?

DT: No.

RM: ...really a politician. You wouldn't think he would be given to such wise sayings, but he said something very wise at one time. He said, "Life doesn't give itself to the man who wants all his advantages at once. Morality may consist in nothing more than having the courage to make a choice." Well, *my* thesis at this time—I've never written about this, but I should—is that doctors are coming out of their medical school and their subsequent graduate training in their specialty without making a real choice and saying, "Now, I am not a doctor but an ophthalmologist, not a generally competent physician..." but an orthopedist or obstetrician. I am being very dogmatic in saying that, but I think that's really it. Anybody who looks at the situation has to say that. I think that people tend to look... There's still enough prestige to the M.D., which comes with the graduate of medical school. You probably as an English person can understand this, because you still have a body of practitioners who carry prestige as physicians...

DT: Yes.

RM: ..."Physicians and Surgeons," as our license plate used to say. When I was licensed in Illinois, as a deputy executive dean there, I was licensed by... What did they call it? Prestige? Eminence. I was licensed by eminence and my license read "Licensed

to practice medicine and surgery and all its branches.” Gracious. [laughter] That lays claim to a kind of grandiosity that I can’t really achieve.

DT: [chuckles]

I have a couple of questions about the Comprehensive Clinic. I’m curious... Who were the patients then who came to the clinic? Was this everyone who came into the U?

[Doctor Magraw nods affirmatively here]

How interesting.

RM: That’s not quite true. There began to be an increasingly separate clinic called North Clinic in contrast to the general medical and general pediatric clinic. There used to be a general clinic where doctors could see their private patients. I and a few others insisted that the patients we saw in our clinic should have student doctors assigned. That really worked very well, because, even though somebody might be referred to specific specialty physicians, for instance, might be referred to me for psychiatric care and diagnostic care, I would always have them examined first by a student doctor. That usually worked very well.

[break in the interview]

DT: The idea for the Comprehensive Clinic, did it take off in other medical schools as well?

RM: Yes, it did in a few, and they’re still going. In fact, some of them have recently come and started. I think Harvard has recently started it. The reason I know that is that one of those students, who lives out here and is now retired, sent me some reprints that showed that this was going on. Yes, it should go on. It should. This is a central function of a physician, in my view. [chuckles] Yes, it is *terribly* important to know how to treat myasthenia gravis or glaucoma or non-Hodgkin’s lymphoma. We all profit enormously for that knowledge. If the capacity to take care of the patient, the interest in taking care of the patient gets lost in this process, something fundamental is gone. I don’t mean to preach.

DT: Yes, I hear that.

When you became director of the clinic, did you stop being assistant dean or did you...

RM: Yes.

DT: You’ve mentioned a fair amount about how medical education was changing and the influence of the NIH. Could you say anything more about the way that medical education was financed, for example how much funding the Medical School was getting from the State at that time?

RM: Precious little. I can't tell you a precise year for which these figures are, but I remember one year in which the Medical School budget was—this doesn't sound like much now; this is ancient history—\$25 million and for the Medical School, the dean's money in part, was just a shade over \$2 million. It was well under ten percent. The NIH funding was horse and rabbit stew. You took one horse and one rabbit and what you got was what you got.

You'll keep me on track by asking me questions.

DT: Yes. [laughter] Certainly.

What can you tell me about the faculty practice issue? I know that this was a hotbed issue when...

RM: An *enormous* issue. That's one of the things in my mind when I said Bob Howard hadn't gotten this due. I don't know if he told you this. I was shocked to learn from him that three different University presidents in succession told him that he needed to get control of the private practice issue, and three University presidents waffled when push came to shove. Did he tell you this?

DT: Yes, he did. Yes.

RM: It was an impossible situation. These men were gung-ho for their private practice and funding, and they wrapped this in various kinds of justification. For one of them at least that I admire greatly, Don Hastings, I think it was, as far as he was concerned, sort of a federalism; that is, a state's rights issue, but for the other guys, like Dick Varco and Don Mosser—Dick Varco was a wonderful surgeon, and Don Mosser was head of Radiation Therapy—and Lyle French, neurosurgeon, and some of the other money-making specialties, they were clearly defending their financial domains, and they were getting very wealthy. It was very easy for me to side with Bob, because I was working ninety hours a week and, basically, getting by on my University salary, which was, as I remember, about \$25,000, and about doubling that with private practice by seeing patients in the evenings and on Saturday. So it was an easy sort of thing for me to side with him.

But, in addition to that, in Two Harbors, we had this prepaid medical plan, and I really recognized that it was wonderful to have a system in which medical fees were not so all important. Now, I'm going to talk against that a little bit and say that there's no question that in the doctor/patient transaction, a patient's power partly comes from the direct exchange of cold cash. Doctors are in an extremely powerful position in that. One of my friends during internship, my roommate during internship, said to me one time, "Well, Dick, it's very simple. I see what you mean. When I was at the V.A. [Veteran's Administration] Hospital, I was the boss. Now that I am in practice in the clinic, the patient is the boss." So I'm sort of arguing against myself. To make the Medical School run, they had to get control of the private practice issue and that took a *long* time coming.

I'm not sure that it still isn't partly out of control. Certainly, at the present time, and in those years, what was happening was that the various departments were becoming extremely powerful. *They* were getting the money. Neurology or even the sub departments like Oncology or Cardiology, they were getting the money. The Medical School Administration had to do with promotions and the prestige of faculty appointments and so forth. But the money was all going in another direction. Students were getting educated. They were not learning some key things. I don't mean to imply that medical education...in the days before World War II when NIH had been faultless, it hadn't been. Any doctors who graduated in that time will tell you that he had lots to learn when he got in practice.

Something really important has changed. That's the Magraw view. I don't mean to say that there aren't different views. If Fred Goetz or B.J. Kennedy or Yang Wang, or particularly Paul Winchell were sitting here, they'd say it a different way. I'd love to have had Dick Varco or Lyle French sitting here and I'd read them the riot act.

DT: I'd like to be there for that!

[laughter]

Another issue that was not just a University issue but was a national concern was concern about manpower and about the pending shortage of physicians. What was your perspective on that? How did that influence what you were doing in the clinic for example, and in terms of your role in education?

RM: [pause] We did make modest increases in the class size. The role that we were playing was pretty engulfing and all-consuming. I became sharply aware of the question you're raising now as a consequence of having written a book called *Ferment of Medicine*, which became kind of a medical best seller and had the effect of drawing me into the national scene.

I should say that the closure of the Comprehensive Clinic was a real distressing experience for me. I did not stay at the University. I took a leave and went to Washington [D.C.] and became assistant director of the Bureau of Health Services and, then, as a secretary of HEW [Health, Education, and Welfare], at the time. John Gardner, he and Phil [Philip] Lee, assistant secretary for health, called me one day and asked me if I would join Phil as deputy for Health Manpower. That year was 1968. So I moved over to HEW and got in the thick of this awareness of the national picture of Health Manpower. I progressively moved into that role.

Because of this book, I'd been going around the country, usually lecturing twice a week someplace about medical affairs. You know, this was a time of, literally, ferment. My book was well titled.

Many new medical schools were starting. I was in a very key intersection to see what was going on. It became clear to me that part of the drive for developing new medical

schools had to do with recognition, sometimes subliminal recognition, that communities that had a medical care system anchored in what became known as an academic medical center were increasingly empowered and that if you had a large section of society, of say 4 or 5 million or so, that had simply a medical care system without the anchoring educational and research center, you were at something of disadvantage. I can cite the circumstance at Rochester and Mayo Clinic as an example, because Mayo Clinic, which was an absolutely superb system of medical care, began to recognize that without a medical school, they were somewhat limited.

There's an interesting personal story about that, because they recruited me to help them develop the medical school. They had a wonderful dean [Director of Mayo Graduate School of Medicine] and I'm going to embarrass myself; I'm not remembering his name [Raymond Pruitt]. I went down there and met with them several times. Owen Wangenstein, who was a major factor in the politics of the Medical School, called me in to read me the riot act about helping them. The surgeons at the University and the surgeons at Mayo were quite directly competitive—other departments, not so much so, not really at all. I'll never forget that because when I started to leave, Owen pulled up his pant leg and asked me for a medical diagnosis.

[laughter]

RM: Owen was not somebody I greatly admired as a doctor. This was his way of getting medical care. Fortunately, I made the right diagnosis. He had fasciculations. He had a lower motor neuron illness arise. He said, "What could it be?" I gave him a number of suggestions, but I said, "You get a consult." I named it the right thing.

Coming back to the story... That became the rationale for developing medical schools in places like East Tennessee or Norfolk, Virginia, where there was a very large population without a medical school where I developed one. It became the rationale for the development of medical educational institutions in Peoria, Illinois, and Rockford, Illinois. Those were big population concentrations without the academic medical center anchoring them.

There was worry that we were going to develop too many physicians. [pause] So for a long time there were no new medical schools built. The way that went, there were well over one hundred, maybe one hundred and fifty, medical schools at the time of the Flexner Report, and that number was cut in half very abruptly because many of them were just lousy. The University of Minnesota, incidentally, was one of the outstanding good ones. I could be wrong, but I think there are now about one hundred and sixteen medical schools. There haven't been any new ones established for a while, but now they're starting to come again. Now this ferment is beginning.

DT: I have a couple of follow ups on that information. When was it that you went to Mayo to help them? Was that in the 1960s?

RM: In the early 1960s.

DT: Okay.

RM: The name of that dean was Ray Pruitt.

DT: Ahh! yes.

RM: A wonderful guy. P-r-u-i-t-t. Ray Pruitt.

DT: Great.

Can you say for the record what exactly was so advantageous about these academic medical centers? Was it the fact that they could bring in the NIH money and the prestige that they had, or was there something else that made them advantageous as compared to just a medical center?

RM: Well, they were putting out graduates. They were putting out knowledge. That was, perhaps, the most important thing because they were sort of generators of continuing medical education. Now, mind you, I sort of belittle the NIH, but the *enormous* outflow of new medical information has advantaged *all* of us. In the 1920s and 1930s, you could graduate from medical school and really not fall devastatingly behind for most of a lifetime of practice. But after these mills of knowledge began churning them out, why it took no time at all before you were in some important measures passé and not knowledgeable about important new developments that made a big difference. That whole system of continuing education was—although, it had many diverse elements to it—reproducible, regularly applicable way, really derived from the presence of the academic medical education and how it fit in with lectures to hospital staffs and renewing of professional cadres by new graduates. Am I making any sense?

RM: Yes, absolutely, very clear.

RM: I might say that was not something that was articulated. As Eleanor Roosevelt, I think once said, “Life has to be lived in prospect but you can only look back and see what was happening.” I would *love* to have some of my colleagues sitting around and say, “Would you agree with this?” [laughter]

DT: That might be something that the Oral History Project turns out doing, getting a few of you together and having kind of a round table discussion. So that’s a very good idea, to see what everyone’s perspective is on this period.

Well, you mentioned this in *Ferment of Medicine* and it seems to tie in a little bit with your comments about the creation of new medical schools. In the mid 1960s, there was also a move towards regional health planning is my understanding. I wondered where you see that having fit in in this ferment period.

RM: I think regional health planning's motivation was, basically, one of the early efforts to get control of costs. The idea was to kind of rationalize the development of expensive institutions and expensive procedures. In some sense, it's sort of a regional approach to rationing as opposed to rationale. It's a perfectly rational sort of thing. I think it was an early attempt to control cost, control the effulgent growth of institutions.

You know, the Hill-Burton Plan which came out just at the end of World War II, was an answer... I keep thinking of these aphorisms. A fellow by the name of Eric Sevareid had an aphorism. He said, "All problems come from solutions." Well, Hill-Burton was an effort to solve one problem of rural health in our increasingly citified or gentrified or metropolitanized society, an effort to sort of put out a sea-anchor and drag... Mind you, I'm entirely sympathetic to that, having practiced in Two Harbors. I know that it is easy to leave these smaller communities behind. The Hill-Burton Plan really, along with the NIH, was something that ushered in an *extremely* expensive system of care. So, as Sevareid said, "All problems come from solutions."

[chuckles]

DT: Do you know what the attitude of the medical school faculty tended to be towards the idea to do regional health planning in Minnesota?

RM: I'm going to express my prejudice. I would say most of the people were looking through that microscope at their own area. They were aware of being tapped to go out and provide lectures for the Camp Release Medical Society, or what have you. That would be an incursion; that would be an extra demand on their time. Some might say, "Well, we've got to do this to be citizens of the state," or to fulfill our responsibility, but I think many more would sort of shrug it off.

I'm interested in your question. Why do you ask that?

DT: Well, I've seen some material in the archives. I don't think it was in the mid 1960s. I might have been later 1960s, early 1970s, but I think it was the Metropolitan Health Board that had suggested this idea in terms of regional health planning and had kind of given a number to each of the medical institutions in the state determining the services they provided and resources they would get. The Medical School, they got a lower designation than they would have liked. I can't remember the reason why, but it seemed to—not surprisingly—upset a lot of people, at least according to what I've seen in the archives. But, as I say, I think this was...

RM: I really should look at that. You know, I'm speaking so *personally* about this—how else can you?

[chuckles]

RM: I do think that the capacity to act as an instrument of society was diminished by the growing fractionated orientation of the faculty members. I remember a colleague in

going to a symposium as he retired that he gave a final comment, final speech. He was speaking about our response as a medical educational institution, and he said he couldn't help but feel as he looked back, that the responses had been too little too late and too self-serving. I can't improve on that.

DT: [chuckles]

Another question related to this idea of new medical schools and the manpower issue... It seems from about 1960, there was this push from Saint Paul physicians to create a second medical school in the Twin Cities. What do you remember about that? Do you have any perspective on that, this effort to get a second medical school?

RM: Yes. I'll tell the story in terms of two people who were very much involved in that: Davitt Felder, a surgeon, and Ben [Benjamin] Fuller, an internist.

Ben Fuller, incidentally, was in Bob Howard's class in grade school. We all went to the same grade school.

DT: Oh, wow.

RM: Ben Fuller, later, came to work with me [in the Comprehensive Clinic]. He has recently died. We established the Magraw-Fuller lectures.

Well, Davitt, typically a surgeon, couldn't stand the idea of the surgeons at the University having more prestige than he. He started out at the University and had gone into private practice. Ben Fuller was not motivated really by the same concern, but he saw the importance of the academic unit as a base for medical care. Ben trained at Mayo after graduating from the University. He had that sort of collective sense about this. They, for years—they were not the only ones—were campaigning for that. It was part of this same kind of sense that there's a pearl here and we'd like to get that pearl metastasized. But the pearl was of different kinds. It was a prestige pearl, and it was a referral kind of pearl, and it was this sort of vigorous magnet of information pearl.

I'm talking to you rather than it [meaning the recorder]. I'm not sure I'm making a lot of sense.

DT: Yes, you are.

The movement to have a second medical school seemed to cause a lot of consternation among people at the U of M Medical School.

RM: That doesn't mean that they aren't equally short-sighted.

DT: [chuckles]

RM: They're moving in on my terrain.

DT: That's interesting. I hadn't realized that Ben Fuller was involved in that. I know Ben Fuller's name from his leadership of the Department of Family Practice. I actually wonder if you could speak a little about the creation of the Family Practice Department and what impact that had on the Comprehensive Clinic.

RM: Well, when the Comprehensive Clinic was discontinued, Ben was asked to stay on and head up the Department of Family Practice *in* the Department of Medicine. [pause] The family practitioners of this state were very much aware of being progressively excluded from the main stream of medicine as it was developing. You understand that in this country as opposed to Britain family practitioners, particularly rural family practitioners but not exclusively so, had an important part of their status in society, their income, and the general prestige in the professional community tied to the fact that they did surgery. Appendectomies are not a big deal, you know. A big deal is to make a diagnosis. Colicystectomies are or were...now they're much more simple. Gastroscopy or endoscopy rather... They were fighting a protracted and bitter, heartfelt battle.

The [Minnesota] Academy of General Practice was a very political organization. At one critical juncture, the head of the financial committee—what am I trying to say?—the Appropriations Committee of the State Legislature was a brother of a general practitioner. They, at one point, gave an appropriation to the University contingent on the development of a Department of Family Practice. Are you familiar with that?

DT: I didn't know that part of the story.

RM: A fellow by the name of Herb Huffington who was a Regent at the University... I always called him "Huffington Puffington."

[laughter]

RM: I rode on a plane with him one time after I left the U and he told me the story about how they managed this. Now, in many ways, I exemplified, at the University, the kind of thing they were talking about, because I was a generalist.

Just as an aside, let me say that a good number of the University faculty came to me as their doctor: Cecil Watson, Don Hastings, Ellis Benson, Lou [Louis] Tobian. They recognized I was generally competent [chuckles]. Which meant I was not a good cardiologist. I was not a good immunologist, etcetera, etcetera. We had lots of good ones. My specialty was general.

The G.P.s [general practitioner] wanted their own and they brought a guy by the name of Ed from Ely, Minnesota. You know his name. He was a general practitioner. He came down. He flew home almost every weekend.

DT: Ciriacy?

RM: Ciriacy, yes.

What happened with Ben Fuller was that the Department of Medicine was fighting a rear-guard action. They were saying, “*We* are the generalists.” And they picked a good one; Ben Fuller was excellent. Ohh, I have to say I had passing angst because I felt I was being displaced. Ben and I were good friends. Pediatrics was doing the same.

[break in the interview as Doctor Magraw takes a telephone call]

RM: Let’s see, where were we? We were talking about Doctor Fuller.

DT: Yes.

RM: Ben had a dreadful time trying to make that [the Department of Family Practice] go, and for good reasons. The political power was on the Department of Family Practice—I won’t say it was *all* there. They were fighting the identity. They were fighting for the rural general practitioner. [Doctor Magraw taps the table three times as he says “rural general practitioner.”] In a way, that was kind of heartbreaking because it was a battle that wasn’t going to be won. It had to be won organizationally. We really as a nation had to develop a system of care based on primary care, and we weren’t doing that. That’s why Mary Lasker and Margaret [correctly Florence] Mahoney were so pernicious in a way, because to the NIH general practice was an anathema.

I’m not sure I want to talk about this but I will and you can shut it off. I think maybe it would be a good idea to shut it off.

DT: Okay.

[break in the interview]

DT: It’s fascinating.

When were you chair of the AMA [American Medical Association] Committee on Undergraduate Education? What dates were those?

RM: How can I do this?

[chuckles]

RM: Do you know how old I am?

DT: No.

RM: I’m going to be ninety in a couple months.

DT: Wow! That’s incredible.

RM: Oh, what years was that? [sigh] [pause] I'm going to say—I'm probably wrong—1972 to 1978. No, it might have been more like 1970 to 1976.

DT: As long as I have a range. In the 1970s, that's good. I can try and check up on that.

Ben Fuller was working in the Comprehensive Clinic before...?

RM: Yes.

DT: Oh, I see.

RM: We did a number of smart things for the Comprehensive Clinic. One of the things, I got a million dollar grant—that doesn't sound like much—a no-strings-attached grant. One of the things we did was we hired doctors in practice to come and teach, to take a sabbatical. We'd say, "Do you want to take a sabbatical? We'll pay you two thousand bucks a month and you come for one month, two months, three months. Your only obligation in that time will be to be the mentor and check medical students." We got some wonderful teachers that way. They were our best teachers, because they could speak so authoritatively. We got them from all over: California, Montana, Carolina, Minnesota of course. They were to come and have a month or two months of sabbatical and refresh themselves and attend rounds of all kinds. That's one of the things we did.

Another thing we did, we hired people like Ben. Ben came full time. He left his practice. He was very good. You never knew him?

DT: No, unfortunately not.

You mentioned that you sat next to Herb Huffington, and he told you the story of how they got to have their Family Practice started. Do you recall that story?

RM: That's when I learned about the tie between the practitioners and the chairman of the Appropriations Committee. He spoke very forcibly about... He said the University established the Department of Family Practice...make a family practitioner as chair or we won't give you this money. That's what it took because the University had a strong prejudice. We used to start their write ups, you know, in all medical write ups start with a c.c., the chief complaint, or p.c., presenting complaint, and, then, p.i., present illness, and, then, p.m.h. [previous medical history]. Those are the three traditional headings of a medical history. Inevitably in this history, the doctor's information or ideas would figure and would always be abbreviated as LMD, local M.D. That was a pejorative term for many people. That was a prejudice that existed and the family doctors felt it.

I started to say that one of things we did with that million dollars was we established a system of having rounds, a conference, on a patient. Let's say, from Sleep Eye, we would bring a doctor and a social worker, and a school teacher if it was pediatrics, or whoever. We'd bring them in and we'd pay them a consultant fee. They would be a

consultant, and we'd have these rounds. That's something I wish would still go on. It was absolutely marvelous in *every* way—not least because of the insights that were provided.

I think about a youngster, a parentally abused kid with bilateral ruptured eardrums from being boxed. Deaf, you know. We present this story, and here's the father and *he's* got bilateral ruptured eardrums. It makes me cry to think of it. That's the sort of thing we'd get, yes.

DT: Yes.

RM: [Doctor Magraw is tearful] [unclear]

DT: That's very sad.

RM: Yes. [whispered]

DT: Even though Ben Fuller had come from private practice and it seems then that he was probably a generalist, the Minnesota Academy of General Practice were not happy with him in that position?

RM: He was an internist.

DT: Ah, he was an internist.

RM: He was not a family practitioner. We did bring family practitioners in on this system of sabbaticals. They were very useful to us.

I'm sorry. I didn't mean to get carried away.

DT: No, no, no. No need to apologize.

You mentioned this connection between the [Minnesota] Academy of General Practice and the State Legislature. Do you recall what the relationship was like between the Medical School and the state during this period?

RM: [pause] Well, in many ways, that's a really a profound question. I think the Medical School connection with the state overtime had been establishing their practicing doctors in Willmar or Olivia or what have you. The doctors generally had very positive feelings about their medical school. In a way, there was that sort of indirect tie. The Medical School tended not to have, except for the School of Public Health, a sense of obligation to the health of the state. Their purview was professionally limited in that regard.

Now, things like their regional medical programs and so forth and other efforts of that kind, legislative efforts, appropriation efforts that were directed toward rewarding the

medical educational establishment for connections with the health of the state, had some effect. But in general, the Medical School was pretty self-sufficient in sharp contrast, say, to the Ag [School of Agriculture], which had the system of county agents and so forth. The Medical School had nothing like that. We really, I would say, felt almost zero responsibility for the general welfare of the state.

Now I have to say in defense of Minnesota... This is going to sound very chauvinistic, but as somebody who has now become familiar with medical care in all parts of the country, the medical care in the Upper Midwest was really far superior to almost anyplace else, *far* superior. That was a function of the Medical School, to be sure, but certainly of the Mayo Clinic. Mayo Clinic had a system of supplying doctors with referral letters that were wonderfully effective in bringing the doctor up to date. I remember getting them when I was at Two Harbors. It really gave an understanding of this disease and where things stood that you didn't have before.

DT: You mentioned *Ferment in Medicine* a number of times, and I have to say I read the book and it's really excellent.

RM: You did read it?

DT: Yes.

RM: How come?

DT: In preparation for meeting with you, and, actually, every person that I've interviewed so far has said, "You must read Doctor Magraw's *Ferment in Medicine*." Every person I spoke to, they refer to this period as a ferment in medicine and this was before they mentioned your book. Of your colleagues at the U, everyone speaks so highly of it. I have to say, it captures so well what I have learned about this period from archival work and reading what other folks have written about it.

RM: You're very flattering.

It grew out of the Comprehensive Clinic. Well, it grew out of all my experience. I started to tell you that I had taken this period of training in internal medicine and found it just so satisfying and I reported on this to grand rounds. I remember the title of that report on a Friday noon meeting was "Psychological Medicine in a General Medical Setting." That was my report. That book was a great fulfillment for me and success. It was something that people were thinking about, you know. Psychological dimensions had suddenly...when I say suddenly, I mean World War II hadn't become front and center. You may have heard that during the war 2500 doctors in the Armed Services, in the Army, were given training in psychiatry to fill the need in the services. They called them "Ninety-day Wonders."

[chuckles]

RM: A lot of those guys went into psychiatry. It was sort of discovered, as it were. I think this is happening now in regard to Post Traumatic Stress [Disorder].

DT: You've said that the impetus for writing *Ferment in Medicine* came from your own experiences. I have to say, what were the reactions of your colleagues in the Medical School? You told me before we put the recorder on the comment from the British physician who said that it had had such an impact in Britain. I'm wondering what was the reception at the Medical School, and, then, more broadly?

RM: Well, I'm surprised at what you tell me that people have referred to it, because I wouldn't say that it seemed to have much impact on the School, per se. You know, they used to say this about fraternities that were having a hard way to go in a given college, "We're big nationally."

[laughter]

RM: Well, I became sort of big nationally and gave lots of lectures. I remember the editor at W.B. Saunders [Company]—that was the medical publisher that published this—said to me, "You're been reviewed in more places than anything but the Kinsey Report." [laughter]

DT: Wow.

RM: Actually, I kept track. I had something like forty-five reviews and I hadn't any idea how hard it was to get something reviewed. So it was widely reported on, and I made lots of friends. It did have an impact. It had an impact. Things were changing, and we all knew it without knowing what it was.

I remember when I was in Korea and I would get homesick, I would have almost a hallucinatory picture of fishing in a Northern Minnesota lake. So when I came back, I organized a fishing group for my classmates and friends. The first time we went fishing, we all went up to Canada. The next morning, everybody got up and was going fishing, but everybody had the *same* question on their mind: Is medicine changing?

[laughter]

DT: It's funny, because I think no matter what—you may have mentioned this in the beginning of your book—period you look at... I mean, medicine is a dynamic field, even in that period before World War II. When you talked about that physicians could still have the same knowledge maybe ten, fifteen years into practice, still there were elements of medical practice that were changing.

RM: They were, but nothing like the change that occurred... Penicillin did it, an enormous change. Before that, the sulphas had also changed it markedly. Think of it! When I was a kid when I was first in medical school, people would drop dead; people in the midst of health would die in forty-eight hours from lobar pneumonia. That means

people like you. People, all of a sudden, died. We couldn't believe what it [what penicillin could do]. [chuckles]

DT: It's incredible.

One of the things that, I'll say, influenced medicine in the 1960s was the introduction of Medicare and Medicaid. I'm wondering what you thought that influence was on medicine at the University of Minnesota. Can you speak to that at all?

RM: A phrase that comes to my mind is something that I think I got from Wilbur Cohen. He said, "The enactment of Medicare was like backing up a Brinks truck to the loading dock of American medicine." [chuckles] You get his point. That's putting the goodies out there.

DT: Yes.

RM: Well, of course, it made an enormous difference in terms of the charity system of care. [pause] I think that it really changed the expectation of the practicing profession. That's certainly was true of the academic profession...changed the expectations of the obligation of providing charity care. But I'm feeling my way in this, because I have no sharp analysis of this.

DT: You have very sharp analysis of a lot of other things in this period.

RM: Well, Dominique, can we shut that off for a minute?

[break in the interview]

DT: We just spoke off the record about coordination of medical care. The move to reorganize the health sciences at the University in the 1960s and the expansion of the health sciences... It seemed in many ways that that could be conceived of as a way of coordinating health care across the different health professions.

RM: It really didn't play out that way. There needs to be a strong sort of sense of public obligation in the thing that looks at the overall picture and makes things happen that are conducive to the end result in society. That has been lacking. I'm sorry. I don't mean that it's never been present, but it hasn't been a dominant feature. I think you put your finger on something that needs to come into the system. There is a dean of the Medical School, or was... In a way, this notion of—if I can leave personalities out of it—having sort of a global approach with educational goals that are participatory to a re-synthesis in getting Humpty Dumpty back together is... If I were czar, I'd try to.

DT: [chuckles]

What do you recall the impetus being for the reorganization of the health sciences in the 1960s, and how do you think the reorganization was received by the faculty?

RM: Do you mean in terms of the curriculum?

DT: The curriculum and the creation of the Academic Health Center, the health sciences then as opposed to the kind of individual schools of Public Health, Dentistry, Pharmacy.

RM: Well, again, I'm sort of feeling my way. My sense is that the approach was institutionally oriented rather than population oriented and service oriented. I think that the structure was a way of answering institutional needs of reporting and delegation and so forth and not a sense of organization of the whole. You know, Ch'in Shi Huangdi, the emperor in Japan [correctly China], got things started, common language, common measurement of axle width and so forth. Those were directed toward the *whole* community. They acted as sort of the strings around which the beads of the necklace were oriented. We haven't had that in medical education. We haven't had that at the level of the AAMC, [Association of American Medical Colleges] the Academic Health Center organizations. I guess maybe we could say we haven't had that at a national level.

[chuckles]

DT: It seems that during your time at the U that the Department of Psychiatry and Neurology were separated into separate departments.

RM: Yes.

DT: Can you explain how that came about?

RM: Yes. That was a matter of personalities. I think it was unwise, personally, but that's retrospect. There was a very driven sort of—I don't need to mince words, I guess—popinjay kind of a guy in Neurology [A.B. Baker] who was bound and determined to have an empire. The then chairman of Psychiatry and Neurology, Donald Hastings, was a particularly interesting guy. He had been the psychiatrist for the Eighth Air Force during World War II, a terribly important role, hobnobbing with Hap Arnold, Dwight Eisenhower, and so forth. Then, he comes back to the niceties of the politics of an academic medical center.

DT: [chuckles]

RM: He really doesn't care that much to fight this. There was a corresponding head of Psychiatry, Burt [Burtrum] Schiele, a fine person, but he's tired of fighting with A.B. Baker. Everything comes with a psychiatric or neurological label on. That's the way it is.

DT: I kind of assumed that it would have been related—at least that kind of national move to separate—to knowledge.

RM: Right. Right. But now the knowledge is coming back together again, and that was predictable. Well...[unclear].

[chuckles]

DT: What were relations like between the Medical School and the affiliated hospitals? Do you have any perspective on that, based on your work in the clinic?

RM: What are you asking?

DT: I guess whether there was any really good administrative rapport between Anker, Saint Paul Ramsey, Hennepin County...

RM: And the V.A.

DT: ...and the V.A., whether there were good relationships or if there was any kind of tensions in the relationships.

RM: Yes, to both questions. They varied and fluctuated depending on the circumstances and the personalities. By and large, the University was the home farm and the others were dependent on it; although, they had lives of their own. Both Hennepin County and Anker, like Saint Paul Ramsey, had constituencies that they drew power from. They had identities of their own. On the other hand, they were grateful for and acquiescent to the uses of clinical clerks, namely medical students, and residents. But, you know, they were individually ambitious and, ultimately, established—I shouldn't say established—they maintained their independence as residency programs. That fluctuated. If there was a time of stringent limitation on funding or numbers of residents, why they'd moved closer to the home farm. If things were more free and easy, why... These are prima donnas who want their own show.

[chuckles]

DT: Within the College of Medical Sciences how were relationships between the Nursing School, Dental School, and Public Health and Medicine?

RM: In the Nursing School, there was a very redoubtable woman by the name of Katherine Densford. You'll be amused by this. You maybe haven't heard she had a fake British accent.

DT: [laughter] I did not know that.

RM: Yes. She was very politically astute in fighting the battle of a downtrodden group, as nurses really were—no question about it. When I was first in medicine at the Swedish Hospital, even as a senior student, the nurses would stand up when I came on the ward. Good God! [laughter] Now things have progressed.

The Dental School has always been a junior partner. People who went into dentistry—I have a daughter who is a dentist, just as smart as the one who is a doctor—were people who couldn't get into medical school; that was the medical school opinion.

The School of Public Health was almost always a peripheral, second rate citizen. But, you know, depending on the individuals and times, they made important contributions.

DT: I'm conscious of the time and your needing to get moving. I'm a little unclear what you did after you left the University. You spent some time at the Bureau of Medical Services?

RM: I spent two years in Washington, first at the Bureau of Medical Services and then in the office of the secretary [of HEW], as assistant secretary. I had office adjacent to his—a great big office. I was on leave from the University of Minnesota. When I came back to Minnesota, I was a tenured professor, mind you, and when I came back here, there was a new chief of Psychiatry—that jerk [whispered].

[chuckles]

DT: You're not the first person to say that. Bob Howard said, essentially, the same thing.

RM: He had no place for me. I was a tenured professor, *full* professor. I wasn't going to beg to come back, so I didn't come back. I left. I had choices to go as dean in Florida...

...or as deputy executive dean in Illinois, and I went there and built three new medical schools within that system and, then, left to be chief and president of the Eastern Virginia Medical School. I went to Illinois in 1969 and left Illinois in 1973.

I, then, went to Norfolk and stayed there until 1978. That was a very interesting experience for me in every way. They were starting a new medical school. They had essentially...

[End of Part 1]

[Part 2]

RM: ... no state funds. I was going to get state funds. It was a very difficult thing. Got it started, but I was a Yankee and that was Tidewater, Virginia.

I can explain the circumstance by telling you one story. The fellow who was reported to be the most powerful politician in Virginia, Sid Kellam, had license plate number one, was appointed to our governing board. I went to pay him a courtesy call. I walked in this *vast* room. I'm sure he said "Hello" to me, but the first thing I remember as I approached him, is he said, "That was a damn unfair war, you know, Doctor." Do you know what he was talking about?

DT: The Civil War. [laughter]

RM: Right. That was his opening statement. Anyway, I left there in 1978.

I had no job for a while. Then, I worked at the Indian Health Service. I did consults traveling around the country for the Indian Health Service. Then, I got a job here at the V.A., not as chief initially, but, then, I was made chief and stayed there from 1980 until 1992, when I retired. Then I taught at the U for about five years half time. So...

DT: That's a prolific career.

RM: Yes.

DT: Just one final quick question. You were recruited to Washington, is that correct?

RM: Yes. I kind of arranged for that because the Comprehensive Clinic had been shut down. You know, I was a big wheel with this book, so I wrote to a friend and asked did they want me? They did.

DT: Excellent.

RM: Yes. That's when I knew Dan Fox.

DT: Right. He told me that you'd authored an article together.

RM: Yes.

DT: I wasn't able to get a hold of the article before coming here.

RM: Will you, *please*, be sure and give him my love?

DT: I absolutely will do. I certainly will. I know he will be happy to hear that. He's taken an interest in my work, and he's a wonderful supporter.

RM: You're lucky to have him. He was a great help to me...a long time ago.

DT: Do you have any final thoughts on your time at the University and about the Academic Health Center, more generally?

RM: I think I told you that my family homesteaded there.

DT: Yes.

RM: They had a big white house that stood where Millard Hall stood. It was moved across the street as a fraternity house.

[pause]

I'm speaking roughly when I say that life can only be understood in retrospect. I wish I had had the capacity to express what I now understand as the problems and for what they were. I do not know that would have carried the day, because things were very hierarchical. I *truly* regret that we were like Burt Schiele said at his retirement, "Too little too late and too self-serving," because that's what we were. *C'est la vie*.

DT: Yes. I want to say it seemed that in *Ferment in Medicine* that you had a pretty good grasp of what the problems were even then. As much as you say you've thought a lot about it in retrospect, it seems that your analysis was quite perceptive at that time.

RM: I'm afraid I've just bored you.

DT: No, you haven't. This has been fantastic. I've *really* enjoyed this interview.

RM: If I can help further, let me know. I think it would be great to get a group together and talk, because we're fading from the scene.

DT: Who do you think should be in that group if we had one?

RM: May I think about that?

DT: Yes. If you'll let me know, that would be great. If you have any other recommendations of whom I might interview, do let me know.

RM: Give me your phone number—oh, it's here.

DT: Yes, right there. So you can give me a call. I'll be glad to try and put that together.

RM: I'm really feeling apologetic. It's like that joke; We've talked about you long enough. How about me?

[laughter]

DT: That's the whole point! Doctor Magraw, you've had fantastic stories. Thank you.

[End of the Interview]

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