

Robert Mulhausen, 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 Mulhausen was born in Chicago, Illinois, on June 7, 1930. He attended the University of Illinois for both his undergraduate and medical degrees. He received his BS in Chemistry in 1951, his BS in Medicine in 1953, and his MD in 1955. He later received a MS in Internal Medicine from the University of Minnesota (1964). Mulhausen did his internship at Ancker Hospital in St. Paul, Minnesota, in 1955-56 and his residency at the Veterans Administration (VA) Hospital in Minneapolis from 1956-59. In 1959, he joined the faculty of the University of Minnesota Medical School as an instructor. He was appointed assistant professor in 1964, associate professor in 1969, and professor in 1973. He also served as Assistant Dean of the College of Medical Sciences (1967-71), Assistant Dean of the Medical School (1971-73), and Associate Dean of the Medical School (1980-87). In 1973, Mulhausen left the UMN Medical School and joined that staff of St. Paul Ramsey Hospital where he served as chief of medicine until 1988. In 1988, he returned to the VA Hospital as the Associate Chief of Staff, Ambulatory Care, until 1995. Mulhausen is a specialist in internal medicine.

Interview Abstract

Mulhausen provides a brief overview of his education and early career. He discusses the UMN Medical School's decision to increase class size in the 1960s, the Health Sciences curriculum changes, and the reorganization into the Academic Health Center in 1970. He discusses his role as the representative of the dean's office regarding facilities management, his role in space planning, and issues of space in the health sciences at UMN. He briefly describes the relationship of Twin Cities affiliated hospitals and the University Hospital and Medical School. He describes his move to St. Paul Ramsey Hospital as the chief of medicine, the establishment of a group practice plan at St. Paul Ramsey, his return to the VA hospital as associate chief of staff for ambulatory care, and some of the changes at the VA when he was there, including new outpatient clinics and reforming billing practices. He describes his research on acid-base balance and blood gas and the importance of obtaining blood gas machines for clinical use. He discusses the failed attempts to combine the University Hospital with the VA or affiliated hospitals in the 1970s and 1980s. He reflects on tensions between family practitioners and internists; house officers and changes in technology and computerization; relations between UMN health sciences schools and within the dean's office; Elmer Learn and the Committee for the Study of Physical Facilities for the Health Sciences; his experience with the human volunteer policy; recruiting minority students, particularly American Indians; the relationship between clinical and basic science departments at UMN; and generally on the UMN Medical School, internal medicine, and primary care and geriatrics.

Interview with Robert Mulhausen

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed on July 13, 2009

Robert Mulhausen - RM

Dominique Tobbell - DT

DT: This is Dominique Tobbell with Doctor Robert Mulhausen on July 13, 2009. We are at 5285 Nolan Parkway, Oak Park Heights, Minnesota.

Thank you, Doctor Mulhausen, for agreeing to be interviewed today.

RM: You're welcome.

DT: Why don't we begin with a little background about yourself, where you were born, for example, where you grew up?

RM: I was born in Chicago and grew up in a suburb of Chicago called Berwyn, B-e-r-w-y-n. I went to college at the University of Illinois in Champaign Urbana and, then, went to medical school at the University of Illinois in Chicago.

I came up here and interned at the old Ancker Hospital, which was a predecessor to Saint Paul Ramsey, which was a predecessor to the current Regions Hospital. Then I stayed in the Minnesota system and took my residency program at the V.A. [Veterans Administration] Hospital [in Minneapolis] and took a master's degree from the University of Minnesota in medicine.

I went on the faculty in—oh, I don't remember; let's see—1959, maybe, as an instructor and worked in the Admissions Department at the V. A. Hospital. Soon I got a job as Assistant Chief of the Medicine Department. It was the largest department there and the largest residency program in internal medicine in the Twin Cities. It was a very large program for its time, maybe, thirty-six residents, something like that. I spent a lot of my time with the residency program, a lot with recruiting and assignments and that sort of thing.

Our chief of medicine when I was a resident was Ed Flink, a superb clinician, professor of medicine at the University [of Minnesota] who went on to start the new Department of Medicine at the University of West Virginia, leaving a vacancy, which was taken by Doctor Wendell Hall, who was a professor of medicine at the University and one of the world's experts in infectious diseases. I worked for him. He was chief and I was assistant chief.

I started doing some research there with a team and did okay. We published some papers. I spent a year in Denmark as a Fulbright fellow in research with Paul Astrup at the University of Copenhagen hospitals. It was a very fruitful year, a wonderful year. That was in 1965. When I came back home, our team had split up for personal reasons.

In about 1967 or 1966—I don't know when; somewhere in there—I was asked by Bob Howard to come over to the [University of Minnesota] Medical School as assistant dean of the College of Medical Sciences. That was the combination of the school [of nursing, medicine, public health, and University Hospital], what it was before the Health Sciences. [chuckles] I was assigned to do a job that I absolutely knew nothing about, and that was facilities management.

Well, there were a lot of things happening at the Medical School in those days, quite a change. It had gone back some years. Bob Howard, I think was instrumental, and some people at the U, in getting started with... There was increasing pressure from the State Legislature and the feds [Federal Government] to increase the size of the Medical School. There was a lot of concern about the number of physicians in the state and a lot of concern about primary care; although, not nearly as much as there is today. But there was some at that time. A lot of the rural physicians, I think, were concerned that they didn't see young physicians coming out to the rural areas.

The class size was 160, which was a pretty good size [for the time]. My size of class at Illinois was 165, so it was a very similar-sized class, a big class in those days for medical schools. Both schools were probably among the top in the country. As Illinois and Minnesota both later showed, that was a drop in the bucket.

There were several studies done that I had nothing to do with. The Hill Family Foundation Study looked at health care and physician need. I think there were some studies done otherwise.

So there was a decision to increase the class size, increasing the class size significantly, some forty students, which was the highest single increase in the country, at the time. It was seven percent of all of the increase in the country, under a program that had been started by the feds. That was the Physician Augmentation Program [PAP]. So under PAP, the school expanded. There were a lot of concerns in the Medical School, I think, about this. Where would the faculty come from, the money, and facilities?

We embarked on a very large-scale building program. I was the dean's representative in this very large-scale, very widely-planned, and faculty-involved planning program for the

Medical School, *and*, for the School of Dentistry, and, down the road, Pharmacy and Nursing and everybody, then the whole Health Sciences. In a way, the whole Health Sciences thing kind of came out, in some respects, of the planning for the building program. I don't believe there was any pressure on the dental school to expand or the pharmacy school to expand. There was some concern, I think, about the School of Public Health, but nothing like the Medical School. The Medical School was dominant in terms of the expectations of the state. I really am not sure how this all got pulled together. That was either done before or else I just wasn't that privy. I'm kind of a green horn at it at this time. That was all new stuff to me. I'm relatively isolated doing my job at the V.A. and coming back after being gone for a year. There was a lot of this stuff that was going on that I didn't quite understand and, still, in some respects, don't know all the inner workings. I think that Bob [Howard] was instrumental in much of this, and I think the University Central Administration was also instrumental in pulling together the Health Sciences. I think one of their first programmatic things was getting involved in the building program. It was thought that by doing this, we could enhance the building program and piggyback it with the Medical School and its enlarging class.

The first stage, phase A, went pretty well. Then B and C, the second stage, ran into rocky things, because, even though it had been approved under an act of Congress, it was thrown off the lists, and we had to reapply. We went back saying that we couldn't go any higher in class size because we'd already expanded quite a lot. We were turned down again. You know, interestingly enough, I can't remember exactly how it all came out, but we did get money finally for B and C. That included dentistry, public health, medicine, and I think F came later. That was my job to help write these projects up. It was exciting.

At the same time, there were a lot of other things being played out because there was a lot of ferment in medicine at the time and curriculum change was one big change. The people that I knew who got particularly involved with that were Dick Ebert, who was head of the Department of Medicine—I think he was a strong proponent for curriculum change; he wasn't alone, but I think he had to be one of the leaders in this area—and I think some of the basic scientists, of course, who were always concerned about the proper balance between the clinical and the basic sciences, which was always a problem, the times, the periods, how much money, etcetera, etcetera. They were treated, probably, reasonably well under the B, C, and A programs. Curriculum, then, became a big part of things. I was on curriculum committees and played some sort of a roll there, although, I played no lead roll. Bob McCollister... I don't know if you know Bob, played a major role.

DT: I'm going to be interviewing him.

RM: Good. Good. He has a *tremendous* background and knowledge especially of the curriculum and all the doings going on back many, many years. Not only that, but he remembers a lot more than I do. We get together every so often, and he can remember many things that I don't remember.

[chuckles]

So he was the representative from the dean's office. [H.] Mead Cavert, of course, was very much involved. He was, as you know, in many respects the guy who made it [the School] kind of go; and Bob Ulstrom, who was associate dean of the affiliated hospitals; and then Bob Howard, who was over all.

I think a lot of that business of the start of the Health Sciences and bringing the Schools all together, in some respects became... The building planning program became part of that. I worked together very closely with the associate dean from the dental school—he's dead now—for a couple years. He was a wonderful supporter of the dental school. We often had to *vie* over space. He was very effective.

DT: Do you remember his name?

RM: Yes. [Mellor] Holland, a wonderful man, a nice man. He *lived* for that dental school expansion. That was his baby, and he worked hard at it, and he was good at it.

Then there was the RPAP [Rural Physicians Assistance Program] and Family Practice, which all became part of this. The Family Practice program had been started by Dick Ebert and the man who ran it was... I had his name the other day; now, I forgot it.

DT: Benjamin Fuller?

RM: Ben Fuller. Ben Fuller started that program. Ben was a visionary, wrote several books on what's going to happen in medicine, kind of a dry guy, but very much dedicated to the program. A person by the name of Tom Rose, another internist, was his assistant. Tom, I think, is still living. Ben died about five, six, seven years ago. A good guy Ben was, kind of a prophet before his time. Dick Ebert started the program in Medicine and chose Ben to head that program. But the pressures from the community were just too much, I think. The family practitioners became very organized in the state and they wanted their own program. They didn't want to be part of [Internal] Medicine.

I might add that not only was the increase in the size of the class important for the building program but the curriculum was, which was supposed to emphasize ambulatory care. Now, this is 1970, okay? and we're still talking about that. That's why a good part of the building program was in clinics, in dental clinics and medical clinics. There was a thought we needed to do more ambulatory care. We sold, I think, a good part of the program on that basis, not only just because of the class expansion, but we needed more faculty and, therefore, more research space, and we needed ambulatory care space. There was very little space at the U Hospital for ambulatory care. The university hospitals had been used to seeing referral cases, most of whom were cases that were admitted to the hospital. In those days, people were admitted to the hospital, as you know. The University didn't have a *lot* of ambulatory care space, because their practice was mostly inpatients and the residency training program were adapted way. At the University Hospital, they had very high-tech medicine and research. At the other [affiliate]

hospitals, it was a little different, and we can talk about that a little bit later. So the need for ambulatory care was a necessity in order to get more ambulatory care space to see patients and to teach ambulatory care. Indeed, the new curriculum took that into account, so that there were ambulatory care programs that were part of the new curriculum. That was kind of a linch pin, again. New curriculum, Student As Learner—whatever that meant; Bob [McCollister] can tell you what that meant—and then the other one was ambulatory care as part of the curriculum. It was a whole new curriculum, a brand new curriculum. It was, actually, a lot of fun. It brought a *lot* of faculty into the planning of the educational program in the Medical School. More affiliated hospital people became involved. It was a grand, I thought, exploration of curriculum. A lot of people were involved, and I think it was a good curriculum. It was different. At any rate, it got people from the various specialties together to talk about their disciplines. I don't know if that was a good idea or not. In retrospect, maybe it wasn't, but we sure had fun teaching it. It was a new experience and a good experience. Parts of that curriculum still linger. For example, they don't call it Blood I anymore...this one. But that's still in part of the curriculum.

[chuckles]

I don't teach anymore in that program, but I see handouts. Occasionally, I see the material, and it's still some of the same case studies.

It's kind of interesting. This was in 1972.

Let's see. What else was going on? Family Practice. The RPAP program had been started, a great success.

Oh, then there was competition in the community, of course, Mayo Clinic and Duluth were constantly champing at the bit, and were, obviously, competing at the state level for funding. These were all headaches, I think, for the administration. These were things that I think Bob Howard had to wend his way through.

The Health Sciences then developed and became one organization. I think this was under President [Malcolm] Moos. I don't know the ins and outs of Bob Howard versus Lyle French in terms of the final decision [regarding the appointment of the University's first vice president for Health Sciences]. I know Bob wanted it. I'm not sure why Lyle got it. That's all I can say. I have my ideas, but none of them may be correct.

Within the Medical School, there was always concern, a big over all concern about several things. One was the curriculum. Oh! this used a lot of people and money. Then there was the building program. I spent my time mostly with department heads fighting, fussing over space. I remember I went to talk with Bob Howard once and was complaining to him about the fact that these men come in and women come in and they fuss with me, and some yell and rant, and some plead, and some argue. I said, "You know, this is hard. Boy, these people are really tough. They really are aggressive." Bob said, "That's why we hired them."

[laughter]

I often remember that. That was important to me in later years, because I became a department head myself. I remembered then why those things happen. [laughter] Bob [Howard] always had all kinds of good ideas. That was one that I very specifically remember. It made things easier after that. The department heads would come and I'd think, "That's why he's here. He's pleading his cause," or "demanding his cause," or "arguing his cause" depending on the person. It made things a little easier for me. It put it a little bit into perspective. I think, ultimately, we were able to help most everybody.

I don't want to lose track of what I was saying before. We said the...

DT: Curriculum and building...key issues.

RM: Oh, the key issues, of course, money, the size of the class, which was part of all of this.

I think an issue that came up—I'm not sure about this—was the issue of the scheme under which the faculty would be paid at the university. It all had to do with the private practice thing. I wasn't involved in that. I was on strict full time. I didn't get involved in any of that. As a matter of fact, I tried to stay out of it. I think there was a lot of concern among the various departments about going to a strict time group practice. When I went to Ramsey [Hospital], we had that. That was some years before the U went into a full time...group practice plan. I think Dick Ebert was for that. I think Bob [Howard] probably was. Again, I don't want to say...because I don't know this for sure. Bob [Howard] was kind of careful how much of those sorts of things he would talk about with *me*. I'm sure he talked about that with Bob Ulstrom or certainly with Mead [Cavert].

Not only that, of course Bob [Howard] resigned. This is about 1970 or so. Then Neal Gault came on, so I worked for Neal then for three years. A great guy, a real strong supporter of the University—not that Bob wasn't; Bob was superb. I mean, [Neal Gault] was and had been until his recent death, an old friend of mine.

By that time, in 1970, 1971, things started... You know the buildings were starting. The new curriculum was going. All these things were going and whether you liked them or not, they were going. Then Lyle [French] took over as director, and I had worked with Lyle with building programs. Lyle, of course, had been head of the building program before he became vice president. Then, Dick Varco took over after Lyle, so I worked with Dick Varco, which was an education in itself, and with Lyle. That was a pretty good relationship. I learned a lot from both of them. Lyle was the quintessential gentleman, a real scholar. He guided the school and the Health Sciences through some tough times. I don't know if he did better than Bob would have or not, but it was different. Well, over all, I think it was probably all right. It was good. Those were the things that I think were going on in kind of an over all basis. There's always fussing going on.

Towards the end, I got involved doing a lot more with getting facilities for people off campus. One of the big ones was we built... [John] Najarian had arrived, and he was doing this ALG [Antilymphocytic Globulin] stuff, and he was making it up in his lab, and he needed *more labs*, because he wanted to produce more ALG. [laughter] We went and rented, or maybe we even bought, an old factory and renovated it. That became his laboratory for ALG.

We got money for that from the feds.

We did some other renovations off and on campus. A lot of the work I was doing, working with Central Administration, was far from doctoring, about how to do rentals and what was needed. Of course, they all needed planning. The space had to be planned and had to be completed.

At any rate, in about 1973 or so, Dick Ebert asked me if I'd go to Saint Paul Ramsey [Hospital] as chief of medicine. They had moved into the new hospital from the old Ancker in about 1965 or 1966 or something like that. There had always been a relationship with that hospital and the V.A. We assigned residents over there from the V.A, but, by this time, Ebert had changed the whole residency program, so there was *one* combined residency program. Before that there were two residency [programs]: one at the U and one at the V.A. Dick Ebert came in, and he pulled all of it together and made it into one University residency, which it is today. Hennepin always remained independent. By this time, Saint Paul Ramsey was part of the residency program just like it had been at Ancker, but the Ancker program had been supplied by the V.A., at least in the Department of Medicine. Surgery was affiliated through the Department of Surgery at the U. OB [Obstetrics] was a separate program. Peds [Pediatrics] was through the U. The big teaching programs were affiliated through the U. Ramsey had a fairly large internal medicine residency group and its own internship program. He asked me to go over there. By that time, all this action at the Medical School had kind of settled in. It wasn't dull but...

I might add that during this whole time at the Dean's office, I would spend a day a week at the V.A. doing research and teaching. So every Thursday, I didn't go to work [at the University]; I just went to the V.A. That was something that Bob [Howard] allowed me to do. It was a little bit of salary that augmented. It was a nice thing for me.

I didn't know very much at the time about the Department of Medicine at St. Paul-Ramsey Hospital, because I was over at the U, and I'd just hear rumors. I don't know why Ebert asked me to go there, except there was a problem, as you might guess. There was a problem. The chief of medicine there, at the time, did not get along with the surgeons at all.

DT: Do you recall his name?

RM: No, I don't—fortunately.

DT: [chuckles]

RM: He's gone now; he's been gone for years, and I don't remember his name. [pause] I don't know enough about it, really. I know the hearsay.

I got over there; I took the job. It was very interesting. Before I accepted the position, I first met with the staff. That was kind of interesting. We met one night at one of the staff's house. There were ten full time people. We sat around; they were all there, good guys, young, all young, good guys. I said, "What do you want to do? What do you want to do here?" "Well, the first thing we want to do is improve our clinics and our primary care, and we want to expand our base, and, of course, we want to continue our residency program." I thought, well, you know, this could be exciting, so I went over there and stayed for fifteen years.

Affiliated hospitals are different, as you know, relatively independent, which, in those days—it doesn't anymore—caused no end of problems with the people at the U. At the affiliated hospitals, there were mostly discussions over faculty salaries, promotions, residency spots, fellow spots, all those sorts of things. People at the U were looking for more places to assign people and the people at the affiliated hospitals worried about their own needs.

Over all, in fifteen years, when I left, we had forty-six full time staff, so we quadrupled, not counting all kinds of advanced nurses and all that stuff. So there was a *tremendous* expansion of the program, and we were making some money, which for the Department of Medicine *ain't* so bad. They don't make money, as you know. They lose money. *But*, having said that, we developed there a practice plan [the full time faculty developed a strict full time group practice plan].

Now, before that, when I first went there, we had a foundation that was a thing called Medical Education and Research Foundation. This foundation paid the salaries, so it was, essentially—it was a non-profit—a strict full time practice. We weren't allowed to do any other practice, unless we brought the money in. Of course, we could do it, but we had to turn the money in. So it was a strict full time practice, and it worked pretty well.

Because I was chief of the Department of Medicine, I was on the Foundation board right away. We were the biggest department, the biggest money maker. Well, in some respects for a non-surgical department, we were, which, of course, is a never-ending problem. I was on the board, and, eventually, through the support of the hospital and our own thinking, we decided to set up a group practice plan. That practice plan, then was a full time practice plan again with its own board. It was a 501-3c. It kind of, I think, helped even out the money a little bit [between departments]. I'll come back to that, because this was an important thing. It's all part of what was happening around the country.

We had a Family Practice program there, but the Family Practice program was a separate program from the U, a good one, as a matter of fact. But the department head didn't want to do any kind of practice outside of a very limited practice for education. He got money from the state, so he didn't have to have a practice plan. He didn't want to do any development, so it became the Medicine Department that developed. We did everything including satellite clinics, expanding programs, anything that would look like we could provide more educational opportunities and more patients for the hospital. We rode that for many years...the surgeons reluctantly giving support because they knew that this meant they would have more patients.

The county which owned Ramsey never was happy with the hospital, and they wanted to get rid of it. They wanted to dump it. Eventually, they did dump it, so then it became a private hospital, and it still is a private hospital; although, even people in Saint Paul today, years later, call it the county hospital. Well, it's no more county than the man in the moon. It's a county hospital in that Ramsey County will pay for poor [from Ramsey County] who come there. They won't pay for any other county, but they will pay for Ramsey county people who come there. In that respect, it's the major place where poor people come, and still do, and it does a marvelous job. It's a good hospital. It went completely away from county structure as a part of the county hospital. That was a long-term problem.

It was, also, the only hospital in Saint Paul where abortions were done. This was something the county didn't particularly care for, but, politically, I guess, were unable to change. There were strong forces around and they were trying to maintain the program under a lot of pressure. I don't know today whether it's still the only one. But abortion is not nearly the cause célèbre today that it was in the 1970s when I was there, and the early 1980s. We would have people out in front of the hospital with placards. Of course, our department didn't have anything to do with it, you know. It was another whole story. In some respects, it set the hospital a little bit apart.

Like I say, the department developed a lot of programs, and we set up the first geriatric fellowship in the Twin Cities. In fact, I think it's still there. We set up an occupational medicine residency program, which is still there. We set up an international clinic, which became the base for the international program at the U now. We had a strong program in training for the advanced nursing program, especially in geriatrics, a *strong* geriatrics program, a separate senior's clinic, which was *very* popular. It would draw all kinds of old people, because they got good care, special care.

We completely rebuilt the clinics. I was chairman of the committee, the outpatient committee. I had a very good administrator [James Dixon] who has just recently quit there as director, who, at that time, was an assistant director who was head of the clinics. He was a very supportive guy. Between him and me and our committee, we were able to build new facilities in the new county hospital. When we got there, I couldn't stand it! We had these great big rooms. We had this green kind of leatherette stuff, chairs lined up. There was a front desk, and you'd walk in there and all these people would be sitting there just like something out of a bad movie, you know. A county hospital outpatient

clinic...I said, "I can't stand it. We've got to build something." So we built a whole new system for that. If you go in there today, it's better even than when we did it. We built a whole new system of clinics and a much nicer arrangement for patients. It was really old fashioned. For a brand new hospital, it was awful, I thought.

Then, I left in 1988. By that time, things were humming along. After that, Ramsey Clinic, which was the practice plan, became part of Health Partners. The hospital was bought by Health Partners, and, now, it's all part of Health Partners, and still doing a lot of its educational activities there with the U. So it's still, I think, doing some strong medical education there.

Then, I went back to the V.A. as associate chief of staff for ambulatory care. You see, I was doing ambulatory care. I'm not really a very good ambulatory care physician. As a matter of fact, almost all of my training and almost all of my practice has been on inpatients. So I don't know about it first hand, but I had good people. Mike Spilane, at Ramsey, who was still there, was a guiding force for all of these things. I just kind of helped get the money.

DT: How do you spell his last name?

RM: S-p-i-l-a-n-e.... He's one of the old timers there now. I think it's one l, not two ls. He's instrumental in much of the primary care geriatrics programs. There were a lot of offshoots. It was some of his ideas and some of his development. He's a *superb* physician who does ambulatory care all day long! Here's a guy who worked...he had this intimate knowledge of what was necessary. We just kind of encouraged him.

We had some very good people, and we developed the programs there. We, by and large, maintained pretty good relationships with the U. Dick Ebert kept things going. Then, the next chief of medicine at the U, Tom Ferris, came in. Tom came out of a place that did not have so much relationship with affiliated hospitals, like here. Hennepin and Saint Paul Ramsey and the V.A. are very strong affiliated hospitals, and they're independent. Most university affiliated hospitals are not like that. Tom wasn't quite as attuned, and he did *not* believe in primary care very much. So I had a lot of trouble promoting people in primary care, a lot of trouble. It would [unclear] They didn't do enough research. Even though they did research, it wasn't the right kind of research. Well, it was all right.

I quit about 1988 and went to the V.A. That was fifteen years. I felt I had done what I was going to do. I went back to the V.A., worked for an old friend of mine, who was chief of staff, and who is now the boss of all this region's V.A. hospitals, [Robert] Randy Petzel. I don't know if you know him?

DT: No.

RM: Randy is a big shot in the V.A. He was, at that time, chief of staff at the V.A. Hospital. Randy wanted to bring the V.A. into the twentieth century; that's what he wanted to do. That was my job. We did it through ambulatory care, of course, but we

did lots of other things with that. He wanted to get the V.A. out of the typical V.A. inpatient care. He was getting pressure for more outpatient care, community clinics, so that's what I did for another five years or so, something like that.

The V.A. is a very interesting place—I know it very well through all these years; that's where I grew up—blessed with wonderful clinicians and teachers. When I was a resident there and a young staff man, it was fantastic. We had world famous people all over the place. They came back from World War II, most of them, and they had already been either residents or they came back and became residents. But, they'd already been proven, so there was no nonsense. They wanted to do this. There was no, "Well, I'll try this." "I'll try that." They wanted to do this when they came back. There was a terrific group of people there, who, like I say, many of whom were veterans and older and faculty, and this was their game. They did a lot of research. They taught. It was a *very*, very popular training program, and it still remains a good place. A younger group now still maintains a lot of it. It's still a very good hospital. There are very few women patients, of course. That was always considered somewhat of a drawback. There are more than there used to be. The residents had a reasonable amount of responsibility, yet they were covered pretty closely. So, basically, it was a good training program, a wonderful training program. Most of the internists of my age who are in the Twin Cities, in the state, were trained there.

We put out thirteen or fifteen [internists] every year. Bang, bang, bang, bang, They'd go out in the state. One of them started the Saint Cloud Clinic. One of them started the North Clinic. One of them has been very active in the Mankato Clinic. And they came out of that program.

DT: They stayed within the V.A. system?

RM: No. No. They mostly went in private practice. A lot of them stayed in the V.A., but in private practice.

There was a lot of research activity. When I was there, we did a lot of research with my group. In later years, I published mostly about medical economic things, teaching hospitals and their costs, health manpower projections, this sort of thing. That's what I was interested in. I had tried clinical and basic research, and, even though I liked it, I was not that good at it. You know, you learn as you go.

At any rate, the V.A. has grown, and it's done some wonderful things. It's a very fine hospital. It's always had problems, because it's a tremendous need. There are a lot of veterans, and they have lots of needs.

When I was there, we established outpatient clinics around the state, and we did a lot of new outpatient programs and tried new things: a new telephone program, which is still working there where you could call in as a veteran and talk with a nurse if you had a problem, and they could guide you in; an over night admission program, so that people who came in for cardiac studies, for example, didn't have to be admitted to the hospital.

They could have them done as an outpatient, and they would have a staffed ward, which was an outpatient ward. That was a new program. I had a lot of trouble with the cardiologists. They didn't want to do that. But I hired, or at least my assistant hired, a crackerjack young lady. She was not a nurse. She was kind of an administrative person. She caught on to what was needed.

DT: Do you remember her name?

RM: No, I don't remember her name anymore. I'm embarrassed because she was really a crackerjack.

I'd go see the cardiologists and say, "Look, this is great for you. All you've got to do is have the patient come in, go down and write your orders. They'll go to catheterization. They'll come back, be followed, and when you want to send them home, you send them home. You don't have to bring them into the hospital! That's an added cost." "Ohhh, I don't know. I don't know whether we can do this. There are safety reasons. Oooh, that's something new." I said, "All right." So I brought this young lady—she was just a little woman and very pleasant—to a meeting with the cardiologists. The six of them sat there in a row, and she told them what she did. "All right, we'll think about it!"

DT: [chuckles]

RM: A week later, "Okay." Two months later, they were the greatest proponents for the whole thing.

DT: Wow.

RM: [clap of his hands] Ha! Ha! Ha, ha. It was a matter of getting the right person in the right spot. I don't know who picked her. I had an administrative assistant. It was a nurse, and I think she picked her. She was a terrific young woman. She knew *exactly* what to say, and how to say it, and how to get the doctors feeling good about it. "Oh, yes, right. Sure. You come down. Everything is ready for you." "Okay." Gradually, it became and still is a big part of their program out there. They bring all kinds of people in for studies, overnight studies, that used to be admitted with all those extra costs. In that respect, we were doing some ambulatory care stuff.

Probably the most fun thing I ever did there was something that really turned out to be interesting. I hadn't much to do in the first year because we were still figuring how we were going to do things. Later on, I had to go and talk with all the staff about these new things we were doing, and they didn't like that. This was a change they didn't like, but they all bought into it, eventually. In the first year, I didn't have much to do. One of the departments I had under my work was a shared thing. It was a program that was run by a department of the administration, and I had some involvement. What my involvement [was], I'm not quite sure, but it was under me because it was ambulatory. What it was it paid physicians who were taking care of veterans out in the state. So if you got sick, you could go to the physician, and you could be seen, and he would bill. One day, I started

talking to the boss and I said, "How do you bill?" "Well, they send us a bill and we pay it." I said, "What? You *pay* the bill, just like that?" She said, "Yes. Oh, we've always done that," to make sure the doctors were happy. I said, "I don't know about that. After all, nobody gets paid like that anymore." I'd come from a place where I did a lot of billing stuff, and I knew that most of my billings, or a lot of them, were Medicare and we didn't get paid in full, but we would still bill. I said, "I don't think we have to do that. Why don't we get Medicare rates and pay Medicare rates?" Ohhh! Oh, my god, you'd think that I was asking them to change the world.

So I went to other bosses, whom I knew very well, because I worked with them all the time, and said, "Look, let's do this." "What!?" I said, "Let's try it. Let's just get a hold of Medicare rates, and we'll just use Medicare rates and they'll use like they always do. They'll send a number in, and they'll send in their Medicare number, and we'll pay them by Medicare... It will be just like they get paid all the time! They probably don't even *know* they're getting full pay, except the secretary in the office." Well, we finally put that through, and we saved a million dollars in the first year.

DT: Wow.

RM: Ha! Ha! Ha! Ha! Two years later, the administrators who fought it all the way got an award for it.

[laughter]

DT: Wow.

RM: I always laugh about that. They got a special award for that program. That was the way it was. In some respects, there was easy pickings, because people were doing it and that was the way it was to be done, and so forth and so on. So you could go in there and say, "Let's try this." "Let's try that." I got a lot of support from Randy Petzel and from the head of the hospital, who was really great, a guy by the name of [Tom] Mullan, who is now retired. He was, I thought, a wonderful director. They all wanted change, you know.

[telephone rings]

RM: Excuse me.

[break in the interview]

RM: Good Lord, you haven't even asked another question.

DT: [chuckles] I know. I've got some follow ups.

RM: Okay, go ahead.

DT: This is all fantastic information.

RM: Is it?

DT: Yes, it really is, incredibly helpful. I'm going to work backwards and just ask a few more detailed things.

RM: All right.

DT: One of those being when you were doing your residency and then you did research after that, what was your research focused on?

RM: Acid-base balance. That was what we did all of our research in. This, in itself, is kind of an interesting story. I don't know if it makes any difference. I like to tell the story because I think it's interesting. The fellow I worked with was very smart, very good, a fellow by the name of Alfred [Al] Eichenholz. He's dead now. He was interested in acid-base balance, and I didn't know anything about it. I got interested in it. He worked with me in the outpatient...in the admissions section when I first started to work [at the V.A.]. He had some ideas. We started work with the pulmonary people, who were kind of interested also. We were interested in blood gases. Now, we were particularly interested in lactate pyruvate metabolism under hypocapnia. That was essentially what we were doing with low $p\text{CO}_2$ s. Our initial studies were using dogs, and we'd hyperventilate them, and then we'd normal ventilate and watch what happens. Eventually, we had a large lab. I think we had about five technologists working for us. We did a *lot* of work, a lot of dogs, some human studies, but mostly dogs, and, later on, bears, and so forth, and tigers, but mostly dogs.

At any rate, we started getting interested, obviously, in clinical work, because we were, obviously, both internists. We saw a lot of cases. So we kind of built our expertise. He was very good at it and I built my expertise up. Another young woman from our residency who came on the staff, she joined us [Ausma Blumenthals]. We would see a lot of these cases, and we'd do blood gases occasionally. You'll be interested in this from your biochemistry background.

DT: Yes.

RM: What happened is that we would do blood gases the old fashioned way, because we couldn't do it any other way. We had a battery kind of thing for doing the pHs. The door would open in the lab and you'd have to reset the... What do you call those? The wheatstone bridges. It would take forever. Then, we did total CO_2 s gasometrically, volumetrically, using the old [Donald E.] Van Slyke method. Do you know the Van Slyke method?

DT: Yes.

RM: All right, using the Van Slyke. That's why we had so many techs, because it would take them all day to do that.

DT: [chuckles]

RM: We would maybe be able to do a half a dozen or two or three a day, for research and, maybe, an occasional one for somebody who really had a tough case and wanted a blood gas.

Then, we heard about the Radiometer Company in [Copenhagen] Denmark. Radiometer had come up with a way to do blood gases on a micro amount of blood. Really, what, essentially, this was a machine that took a sample of blood that went into a capillary tube, and you had two known $p\text{CO}_2$ s, and you measured the slope of CO_2 [buffering hemoglobin] and you did a pH on it. If you knew the pH, you could tell where on that slope you were, and you could, then, determine the blood gas.

This was called the Astrup Method, after Paul Astrup, who was a very well-known—he's since died—Danish laboratory medicine guy, a physician, who made his mark in life during the great polio epidemics in the 1950s in Denmark. I visited this hospital. This was their infectious disease hospital and here are all these beds encircling a large room, and these beds were full of people who were on respirators. His job was to sit in the middle and do blood gases *all day* long on these people. That was his job during this terrible time of the polio epidemic. He got interested then in that went ahead and pursued it with the Radiometer Company.

So we said, "Let's get one of those machines [spoken very softly]. We ordered one of those machines, and it arrived at our hospital. This was *unbelievable*, because what had been taking a half a day to do, we could do a blood gas, literally, in three minutes.

DT: Wow.

RM: That was it! You could do it faster if you were good at it, but I could do it in three minutes.

DT: [chuckles]

RM: The girls, the techs, you know...well. So this meant we could do *clinical* blood gases. Okay? This is about 1962 or so. Just think about that. I was a resident, in 1956 to 1959, and you couldn't get a blood gas. When I was a medical student before that, you couldn't even get a sodium or potassium in Chicago at the Cook County Hospital or anywhere unless you went to somebody's research lab. But, at least by the time I graduated, you could get a sodium or potassium. But a blood gas? Un, uh. It turned out, just by happenstance, that we were the first hospital in the state, literally—we had to be; maybe the Mayo Clinic had one; I don't think so—to have a blood gas machine that could do clinical blood gases.

Sooo...this meant, obviously, a *lot* of people were interested. We went on the hustings. We would be teaching all over the place in every county—well it seemed that way. We'd be out talking about how to do blood gases and what it meant, because people were not trained. What's metabolic alkalosis? They just didn't know. Well, we didn't know very well either.

In 1964, we decided to have—I think this had to be one of the first symposiums that the V.A. ever held--an international symposium on acid-base balance in 1964. We had Paul Astrup come and Arnold Relman—do you know Arnold Relman?—...

DT: Yes, I know his name.

RM: ...and people like that who came and gave talks.

At that time, there was, the *New England Journal* called it, “the great transatlantic debate on acid-base balance.” This was about 1963, 1962. Relman and company objected to the Astrup Method—not the method. They objected to the way he portrayed the results. They didn't like the portrayal of their values, you know, the standard bicarbonate, all that stuff. They didn't like that, so they had letters to the editors, and that lasted about a year or two. I can remember at that symposium having lunch with Relman and Astrup, and they were sitting and writing on white napkins, writing out and drawing diagrams and arguing. We published the whole symposium in the *Annals of Internal Medicine*.

DT: [chuckles]

RM: Well, it was really pretty heady stuff for a couple kids.

I published some stuff there, too, and, then, I went to work for Paul Astrup in Denmark under a Fulbright Research Fellowship. That was a good year for me. We published two or three papers, something like that. That was a wonderful experience for me and my family.

DT: Being able to test blood gases clinically, how did that change practice?

RM: Oh! yes, well, because you couldn't before. You had to go by the laboratory CO₂ method, which, at best, is kind of a... It's an okay method. So they were using venous CO₂, but, of course, then you couldn't tell respiratory alkalosis from metabolic acidosis, and there were a lot of mix ups because of that. You depended upon electrolyte patterns or anion gaps. Are you familiar with those?

DT: No.

RM: Oh, all right. At any rate, those were other clinical methods that you used. But, you know, blood gas made a lot of difference, and it was a wonderful educational tool.

Of course—I didn't really finish this—what happened was that every hospital in the *state* bought a blood gas machine. Then, the *technology really* got good, and technology, then, became like it is today. You know, you just put the blood in and it reads out. That's nothing. You just don't realize that not so many years before, it was really something and you didn't do blood gases. They weren't around.

Here was the other thing: the physiology of this all was done in the 1920s and 1930s, and *extensively*. [Lawrence J.] Henderson, Van Slyke, [Robert F.] Pitts were all doing this sort of stuff and were doing it using these old methodologies, and I might add a very famous scientist in this country, Horace Davenport, a physiologist at the University of Michigan, who wrote the first little book [*The ABC of Acid-Base Chemistry: the Elements of Physiological Blood-Gas Chemistry for Medical Students and Physicians*] on acid-base balance, which came out in the 1950s or so [1947]. It wasn't very helpful, because people weren't doing much blood gases. It just was too time consuming and just too expensive.

This meant then that the people had another part of the armamentarium that *did* make a difference. The ability to follow them and... [pause] Well, there were all kind of those little things that happened during the years, and, even after, when I was at Ramsey, we had some fun things with that. By that time, acid-base balance was getting into the curriculum. The students were much better at it, even though they always had it in physiology, but they never used it. There was *very* little in the current literature. Of course, after all of that, then all the literature just bloomed with acid-base balance stuff. There were just, you know, all kinds of studies being done and much of it out on the East Coast in the big schools. Arnold Relman was one of the pioneers.

DT: That's fascinating, as you say, that so recently things were so different.

RM: Fairly recently.

But, it's kind of funny—I'll tell you one more quick story—how things come and go and how things sometimes get reinvented. At Ramsey—I don't know when; this must have been in about 1980, I'd say—late in the afternoon, one of the residents came and he said, "I have this patient who is a diabetic in ketoacidosis, and he's got a phosphate of zero. What will I do?" A phosphate of zero? I went to the books, and tried to find what to do about a phosphate of zero! Well, I couldn't find much. I called the pharmacy and said, "What do we do?" "The best we can give you is some phospho soda and you could give it him." Phospho soda, it turns out was the right stuff to give. So we gave some to this patient, the phospho soda, and his phosphate came up. This was during the recovery phase of diabetic ketoacidosis. I said, "This is unusual. Why don't I know this? Why don't I *know* this?"

Well, it just so happens that in about—let's see, before I graduated in 1955—Ed Flink, who was chief of medicine at the V.A., at the time, wrote a grand rounds. Everybody had to write a grand rounds in those days. Residents had to write one a year. They were a wonderful experience. He wrote a grand rounds about diabetic ketoacidosis treatment,

because everybody was always nervous...how do you treat them? He wrote about phosphate. You know, I had been looking at all the newest textbooks and couldn't find a *word*! There wasn't even a word about phosphate, and, right here, he's got all the studies that were done on phosphate and so forth and so on. I'm looking at it, and I say, "God, how come I didn't know that?"

DT: [chuckles]

RM: I knew Ed Flink's work. Then I went and looked at the research being done and what was the literature. During, I don't know—don't quote me on this—an extended period of time, there was hardly anything in the literature, including the clinical literature on the treatment of diabetic ketoacidosis with phosphate. Then, it began to reappear. There was this gap. There was like a whole series of time when it just kind of got lost. It was a little embarrassing to me. I should have known that, but whatever. Anyway, it was a wonderful lesson for me and a lesson in several things. As it turns out, most diabetics don't need any phosphate, because when they get better, they eat and the phosphate comes back. Then hypophosphatemia became a big deal in other conditions and caused all kinds of neurological problems...so there was a lot more interest, all of a sudden, in hypophosphatemia. To make a long story short then, the other lesson was that sometimes things get lost in the literature. Kind of interesting.

DT: Yes.

RM: I think a lot of acid-base stuff kind of dried out because there was no way to do clinical work. [J. P.] Peters and Van Slyke and Henderson, those people, they did a lot of the physiology. Wonderful.

DT: Yes, that's fantastic.

RM: Well, that's a long story.

DT: No, no, no, very interesting. I'm interested in medical technology, so it's a very good story.

You said that you were recruited, basically, by Bob Howard to enter Med School Administration.

RM: Yes.

DT: Why did you decide to...?

RM: I have no idea why Bob asked me to do that.

DT: But why did you decide to go into it more?

RM: Oh, because I thought it would interesting, and I thought maybe I needed a career change, and the work at the U would be another experience. I was still fairly young, quite young I guess. I thought this would be a good experience, and because I didn't know any better.

[laughter]

RM: It was a good experience.

DT: When you got there, there were several other deans in the dean's office? Is that right?

RM: Yes.

DT: Do you recall who was there and your relationship...?

RM: Yes, it was Bob Howard, Bob Ulstrom, Mead, and Bob McCollister.

DT: How were your working relationships?

RM: Good. Yes. We'd get together, I don't know, maybe once a week and talk about things. I think probably at first a lot of stuff went over my head, because I just didn't know the people or didn't know the circumstances and so on. It was good relationships. I still see Mead every so often and I see Bob McCollister fairly often. Bob Howard, when he was in town, we'd see, but he's been gone for so many years now. We used to correspond, but we don't anymore.

DT: Some of the questions I'll ask you, you've kind of covered a little bit. I'm just asking, basically, more for follow up. I'm really intrigued, very excited, to know that you were the dean of facilities management, because that's a part of the story of the expansion that I haven't really seen in the archives. So, as dean of facilities management, you said you were...

RM: I wouldn't call myself *dean* of facilities management. I was the representative of the dean's office.

DT: Okay.

RM: [chuckles]

DT: Your primary responsibilities were with planning and the building?

RM: Not so much the building, but the planning.

DT: Okay.

RM: I never really got involved very much with the building. You know, we worked with the architects very closely. That was TAC [The Architects Collaborative] from Boston. That was the biggest one. TAC. Oh! that was always a problem. They liked this; we didn't like that or the faculty didn't like it. But it worked out. You know, those are normal... That was the other thing that it taught me. This happens. This stuff happens. I don't care where you are, you're always going to have people who think this, people who think that. You've got to kind of help get it to the right spot. [chuckles]

DT: You mentioned, and I actually read elsewhere, that space issues can be kind of contentious between the faculty...

RM: Oh, man! they were probably more contentious than the money. Yes, probably more contentious than money. I think I probably took a little heat on occasion. I tried to get the information to the right people, either to the dean or to Lyle [French] or to the committee—oh, well, usually through the committee—so that they knew what was going on. I made very few decisions by myself. I had my ideas, but I tried to be a facilitator, I guess. This was all new to me, this sort of thing. All of this was new. At first I didn't understand anything. You know, a square foot is a square foot.

DT: [chuckles]

RM: But, I learned a lot about what goes into these things, which I've forgotten. It was a brand new world. That's what I think was intriguing. It was non-medical. Maybe I suffered because of that. Maybe that was not good for my medical career, but, in retrospect, I don't think so. I think it was a great experience. It was often *very* contentious. Yes, I had a lot of heated discussions with people. It was usually friendly. ... But, they were heated discussions. People would come down boiling mad.

DT: Would it just be people within the Medical School or would there be contention between nurses and...?

RM: Early on, I had more to do with the School of Public Health than I did with dentistry. The School of Public Health deans with whom I worked mostly were good people. I think they knew what they wanted and their needs maybe were not quite as... Well, they weren't as needy. How about that? That's a good way, probably, to put it. They weren't as needy.

[chuckles]

RM: So mostly the Medical School. Like I said, in the dental school—Mel Holland was his name—Mel was very good at this. We worked together a lot, because we were both kind of doing the same things. Mel was a strong advocate for the dental school, and the dentists, I think, came out pretty good under the whole thing.

DT: I remember seeing—this is jumping forward a little bit—in the mid 1970s... You mentioned that the State Legislature had approved the funding for the expansion, and, then, they kind of reneged on that, kind of put the kibosh...

RM: The feds did.

DT: Oh, the feds did?

RM: The feds reneged.

DT: Okay. I remember seeing in the mid 1970s—I guess this would have been back when you were then at Saint Paul Ramsey—that some state senators were even getting skeptical of the AHC's [Academic Health Center] demand for more space. So they were starting to say, "You keep asking for more all of this space, but you have plenty of space."

RM: Well... [sigh] What would you say if you were driving down and you were a state [legislator] and you drove around University Avenue and you saw all these monoliths?

DT: Right. [chuckles]

RM: I mean, you'd say, "Isn't that enough space?" It was that sort of thing. Vacuums. Medical schools abhor vacuums. They...pffft! I really had nothing to say about that. In other words, I felt, in general, that people were using space reasonably well. Now, there were always exceptions. Okay? There would be empty labs around and this sort of thing. But, you know, they maybe were recruiting, so they didn't want to use a lab. So if you're a state senator and you don't know that sort of stuff, you look and you say, "Why isn't that lab being worked...?" "Well, we're waiting for somebody." "Well, why don't you use it in between?" You know, you can't...I mean, you could, but, then...ahhh, well, that's hard to do. It's not easy to dismantle, move in and, then, move out again. I think, a lot of times, a lot of these sorts of things became part of all this. "I'm getting a new person coming in and I need *thousands* of square feet for this guy to do his research." Well, you know, "Yes, all right. Let's see what we can do somewhere." I suppose sometimes they showed up and sometimes they didn't. This is all part of that game. I learned how much space meant to recruitment. So I think that's where they'd get *mostly* upset, because they'd have somebody... "We're on the verge. This guy is the greatest" or "This woman is the greatest in the world. We've got to have it. We've got all this set up and we don't enough space for that person." [clap] "Get us some space!" So we tried.

DT: It really seems to me that—and today, still—that space is such leverage.

RM: Oh, yes, it never goes away. I'd meet with people from elsewhere and they all had the same fuss, the same concerns, always a need for space. I hate to think what would have happened if we hadn't got that space, especially nowadays when they're talking about expanding the class again and this sort of thing, and there's not going to be any

money for space. I think you have to realize, too, that money was... Well, I shouldn't say this, because I really don't know that, but I got the idea that money was a little easier to get. There was a lot of interest in expanding, and the University of Minnesota expanded, and it did everything that the state wanted...a strong Family Practice program. I think that the State Legislature has to be really... Of course, today, they don't think about those things, but in those days, it maybe wasn't as fast coming as they would have liked it. I think the University Medical School paid off pretty well for that: big class size, a lot of people staying in the state.

The University Hospital is another whole story. I don't know anything about that. The hospital never got a part of all this. They wanted to be in at first, because there was a need for a new hospital in the early A, B-C stuff. John Westerman was involved a lot with that, but they never really ended up with a lot of space. I don't know that they got any new space, come to think of it. They might have gotten a little bit here and there. So they had to wait, and, of course, that all turned out to be entirely different than any of us would have ever thought about; although... Well, that's another whole story. I better not bring that in.

DT: If you have information to say about the University Hospitals, I'm definitely interested in hearing it.

RM: Well...it's not the way you think. When I think about it, it was a little bit of a Don Quixote thing. At one time, the county hospitals were... Oh! you have to realize the V.A. was going to go over there. Remember, early on, the V.A. was going to go over there, and somebody—I'm never quite sure who—decided no, eventually.

DT: To the University?

RM: At the University. I'm never quite sure who said, "No." The V.A. then went on and built its own hospital. There was a lot of division about that. Some people really wanted to go there, and some people said, "No, not now. We're fine here. We don't have to. We're okay." I was supportive. I was reading over this 1973 thing, and it was *all* about the V.A. coming over there. But, it never panned out. I could see how there would be concerns at the U, big concerns, but I don't know. I was not privy to any of that.

Later on, in later years, in the 1980s, the people at the county hospitals approached the University and the University Hospital about combining our hospitals and practices into one great big plan. Well, of course, that would be a Medical School thing, not hospital. We talked, and we didn't get very far. We thought that would be a good thing to do. There were several reasons why but the big thing was that both of the county hospitals were used to going out after patients and the U wasn't, particularly. They weren't as aggressive as we were, I don't think, at the local community level, but I think that was about it. The other thing was that we were doing reasonably well with our practice plans, and we could see maybe... Oh! there was one other thing and that is that the community, the greater community, wasn't particularly referring cases to any of us. The U was

getting a sizeable amount of referrals, but most of them were for outstate, *relatively* little from the Twin Cities. Then we had the Mayo Clinic and its encroachment, so we said, “Well, maybe what we should all do is go together and make one great big medical practice, hospital consortium, all go together.” At that time, the county was not so anxious. At Ramsey and Hennepin County Hospitals, at least the leaders said they thought this might go. Well, I think the hospital people got nervous. And maybe that was right, because they eventually ended up then with a new hospital and their practice plans and so forth. Some of us thought that that might be not an unreasonable thing to do, but we never got very far. We talked with the clinical chiefs about it and one of the top committees. I think they never got any enthusiasm.

DT: This was in the 1970s.

RM: Nineteen eighties, I think. That was later.

DT: Okay.

RM: Yes, this was after our institutions were pretty well set. We were still struggling for cases, but at least we were expanding and business was going along. There was this kind of hanging on of the strict academic types who said, “Well, patients are just going to come to us.” Well, they don’t anymore just come to you. We found that out early. I was, for a time, on the board of the Ramsey County Medical Society, and they really were kind of hostile to us, the county hospital. They weren’t going to send us cases. We could have the best medicine department in the country and they wouldn’t send us cases, you know.

DT: Why were they so hostile?

RM: Well, because we were taking cases, patients. Sure. Competitive. We were competitive instead of being the county hospital. We were being competitive, and the same way with Hennepin. Of course, Hennepin has a *very, very* good relationship with the *community* that we did not have in Ramsey County. Ramsey County always wanted to get rid of that hospital, and the people who *lived* in Ramsey County thought it was a terrible hospital. “The county hospital? Who would want to go there?” Whereas, in Hennepin, “If I’m in an accident, take me to Hennepin.” That was the thinking, and, then, always good support for the hospital from the community, from the county. That’s been the difference between the two hospitals. So they’ve really expanded and grown. I think they do a wonderful job. I just had a grandson who was admitted there with a fractured skull and he got great treatment, great treatment. They’ve really flourished. There was the thinking, well, we’re all one medical school now of training, maybe we should think about it. But, that would have been a *tremendous* commitment and, god knows, the political thickets would have been very difficult to get through. So, it was probably just as well.

DT: It seems that concerns about hospital census, the number of patients that the U was getting in the 1960s, after Medicare and Medicaid passed was a real issue. Could you

speaking to that at all, about how the introduction of Medicare and Medicaid maybe changed things at the U?

RM: [pause] Uhhh... Now, I'm talking from weak information, because that was before my time, but my *understanding* of it was that there were these patients that were on county lists or something like that that they would get. Of course, with Medicaid, they wouldn't automatically get those patients. Of course, everybody worried about Medicare, but that was the salvation to every hospital in the country.

[laughter]

RM: I think one of the problems there was that their base in the community was narrowing always. You had these clinics coming up, and they were great institutions. Park Nicollet and all these groups, the North Clinic were all mini Mayo Clinics. They used that kind of a model, and they were running their own hospitals. So the University was *not* a clinic like that. The University was departmentalized, and I don't think they particularly go out to recruit patients, which is the Department of Medicine's responsibility—it was, I felt, at Ramsey—and they didn't for good reasons. I'm not arguing that. It's just that they didn't. As part of all of this, I looked at where their referral patterns were in those years. Their referral patterns were mostly outstate. They didn't see many people from the Twin Cities. Well, this is where most of the people live in the state. [chuckles] Now, I don't know whether it isn't still a problem there, quite frankly.

The technology wars are different than they were. Now, you've got technology all over that place. In those days, you had the technology because you had the people who developed it. Well, now, technology is all over the place. The U has some very specific problems, I think, in terms of that. They're difficult. I think they're very difficult problems. I'm not sure what are the answers, quite frankly.

DT: It seemed when the Department of Family Practice began in its early years and there was concern about how to get the patient population in and for teaching material as well, one of the ideas put forward was to have this kind of insurance, this group practice...

RM: Yes, yes, yes, yes. We set up kind of an HMO [Health Maintenance Organization].

DT: Yes. Then the University more generally tried to set up an HMO a few years later.

RM: Yes.

DT: Do you know much about that?

RM: No. I know my own experiences with setting up HMOs. I was very involved with setting up an HMO at Ramsey.

DT: Oh, really?

RM: Yes.

DT: I'd love to hear about that.

[chuckles]

RM: [pause] Well, the Ramsey health plan had good leaders. One of them became head of Group Health here and Health Partners, and, then, he went out to the big one out in California. He was our manager. We were just the piddley Ramsey health plan. We started an HMO.

DT: What was that gentleman's name? Was it Halvorson?

RM: Yes, George Halvorson. I, later, worked for George. When I left the V.A., I went to work at Health Partners as the director of their educational program. George was the boss then, but he left soon after. George was an interesting guy. He tried to get the Ramsey health plan going, but it died. I think it went for a couple years, two, three years. Everybody was kind of exploring. We got involved with Group Health in some way or another. Then that became Health Partners.

Well, as far as the U was concerned, they tried it, and I don't know anything about it. I don't know anything more than that. Ours was funded some by the hospital, and, if I remember correctly, some by the partnership. It was fairly cheap for patients, if I remember correctly. Well, I don't remember very much about it. I was on the board of directors, and I used to meet regularly with George Halvorson. But I don't remember a lot about it. We tried. That wasn't unusual, I don't think, in the Twin Cities in those days. This was all the beginning of the HMO stuff. No, I don't know anything about it. That was all past my time at the U.

DT: Something that was taking place it seems during your tenure were the efforts to get a second medical school in the Twin Cities, to have a medical school in Saint Paul.

RM: Ohhh, yes, yes. Yes, yes, yes, yes, yes. Ha, ha, ha. I forgot about that. You know, I really have forgotten about it. Gee, where was that instrumental? I think that came out of the people who practiced at Miller Hospital, but I'm not sure. It's now United Hospital in Saint Paul. Ummm... I think it was a threat, but I'm not sure that it was really, in the long run, a big threat. I don't think the people there really understood what they were talking about. Now, Duluth was already in the business, and they did kind of know what they were about. But, yes. Maybe I... For some reason or other, it seems to me that the Saint Paul thing was never really a big threat. There was a lot of fussing at the legislature....I don't remember that that we really paid attention—well, we paid attention, but I'm not sure that it ever reached the level that, boy, we've really got to worry about this. I don't remember that. Mead Cavert would know that better than I. Yes, it was one of those burrs in the saddle sort of things. There was that and Duluth and

the Family Practice. Oh, good Lord, they were all... There was a lot of *ferment*. Things were happening. That was part of the excitement, I guess.

DT: It really seems that the local physician groups were quite activist, that it was, as you say, the kind of local groups in Saint Paul who were agitating for a medical school and, then, the family practitioners who were agitating.

RM: Agitating for family practice. They agitated. They were very effective at the legislature, *very* effective, and they remained very effective at the Medical School, I might add. Ed Ciriacy was strong. But they always fought for the Family Practice program.

DT: Ciriacy was [Benjamin] Fuller's replacement?

RM: Yes, Ed Ciriacy.

DT: It seems that Fuller left because the Minnesota Academy of General Practice didn't really like him.

RM: I think they probably gave kind of no confidence sort of thing. I don't know that. I've forgotten exactly how that worked, but that seems to me my remembrance of it. He had a certain style and they might not have liked his style. I think he had a certain very clear idea about what they were going to do, and I'm not sure it was any different. Ben and I used to have a lot of discussions. He had this long view of things. I don't know enough about the Family Practice thing in retrospect to know how his ideas differed from the family practice community. I think they just didn't feel comfortable with an internist running Family Practice really when it got right down to it, and maybe they didn't like his style. He was kind of a dry guy. He was not a slap-'em-on-the-back. He was here is it and this is what I think. That's what *I* think, so I think they just didn't see him as a guy who would be... And I think they were scared of the internist. He did come out of Ebert's department. I think Ebert felt strongly that we need to have a group like this. Well, but Ebert probably realized, too, very early, that this is going to be a distance Family Practice. [pause] It's hard to talk to an internist about family practice, I think.

DT: Why is that?

RM: Well, because they are close but they're not. Do you know what I mean? They're primary care, but they have, I think, kind of a divergent way to train and to look at things. I'm not sure one is any better than the other. Family Practice is here and to stay. I know some very, very good... As a matter of fact, our Department of Medicine, inpatient service, trained every family practitioner who went through the program at Ramsey, and they all *loved* our program, you know.

I'll tell you a story. This is another story. To the head of the Department of Family Practice, one day, I said, "How come you never refer patients to us?" We were talking just like you and I. "How come you never refer patients to us?" "Well," he said, "that's

because we send them to the Mayo Clinic.” I said, “What do you do that for?” “Well, you have one endocrinologist. They have three or four. So our patients have more options.” I didn’t know what to say. I thought I ran a pretty reasonable Department of Medicine with good care. I even get family practitioners who trained on our service, and the department wouldn’t send patients to us. They’d send them somewhere else! You know, what do you think of that. Aren’t we good enough? Are they so much better? Then, of course, I went to Mayo Clinic as a patient myself, and I found you only go to *one* doctor! You don’t see ten doctors. You usually go to one doctor like you do everywhere else. [laughter] That was something that I never could quite figure out.

DT: That’s interesting. That’s crazy. [chuckles]

RM: I may delete that from the...

DT: You can do that in the transcript, for sure. I’ll leave that up to you. That’s an incredible story.

[laughter]

RM: He went on to become the head of a Department of Family Practice out East somewhere. He was very good at it.

DT: It seems there are tensions between family practitioners and internists are still there today, potentially.

RM: I don’t know. I think there is such a need for primary care. They’re working together and they train together. That was the thing that kind of changed my mind. I’d listen to the house officers, and they’d say, “Oh, these guys are good.” I’d say, “Oh, okay. They must be good.” I got to know some family practitioners after they trained. We had a couple working for us in some programs. They were good. They were very good. So I think that kind of modulated my feelings about it all. I never really had too much problems with it since. I haven’t. I’m a dyed-in-the-wool internist, of course, but, still and all... They come out well-trained. In Minnesota, they come out well-trained.

DT: Yes. Yes.

I actually have a question about residents in the 1970s. This would match onto when you were chief of medicine at Ramsey. It seems at the U the house officers started being quite activist and wanting to have their status changed from students to employees so that they could collectively bargain for higher salaries. Do you recall much of that agitation?

RM: Well, no, not really. I’ll just tell you two things about that. Number one is that we had to pay tuition to the University when I was a resident because we were students, and we got our income tax returned as a student. But, of course, as you know, this was later outlawed.

DT: Yes.

RM: That was the universal talk, I think, in those years among residents around the country. There were a lot of issues of work and until that young lady—what's her name? [Libby]—in a New York hospital that didn't get treated and died, that issue... There were a lot of complaints about working hard and too much on call and not getting enough money. Here we are and, of course, they see the faculty. "We're doing the work; they collect." Well, it wasn't *quite* that way. Until you get be a faculty member, you don't quite see that. It isn't quite that way. There's a big responsibility issue.

The only other time I ever had a house officer group give me trouble was [when] we put in a new program. [chuckles] This was my first experience with this. At Ramsey, we put in a new program of computerization. It was such that the intern could write up orders to the nurse and he did it on a computer...rrrrrrrrrrrrrrrrrr! It would print out immediately to the nurse on a printer, so it had this kind of printer stamp on it, you know. They'd take it out. The interns came to me one day and said, "We won't use it anymore." I said, "Why not? What's wrong with it? This is a good idea." "Well, that's the problem. It's too fast, too prone to mistakes." In the old way, you wrote the order. The nurse took the order off and reviewed it. She wrote the card out. It was reviewed again. It went to the nurse who gave it, and she reviewed it again. So there were places along they were picking up the problems.

DT: Yes.

RM: This way, it had this kind of finality. [clap] Rrrrrrrrrrrrrrrrrrr! And the mistakes that were being made were made, like that. The nurse said, "Oh..." without really checking. It turned out that there never were any mistakes that I knew of. Maybe there were, but I didn't know about them and certainly no serious ones. But that bothered them terribly. I said, "You're not going to do it anymore. I went to the hospital and I said, "We're not doing it on our medical wards. Sorry. The interns won't do it." "Okay." I'm sure that it was restarted again later on with no trouble at all. It was new.

DT: Yes, it was change.

RM: It was change. To my knowledge, we never had any real fussing among the people at our hospitals that were rotating through about union problems, but I think that was in the air at the time. There was a lot of talking about that during those days.

DT: Was this the late 1970s when the computers were introduced, or was this a little later than that?

RM: [pause] I would say it was in the early 1980s. Everything was written up till then and still written after that. You still had to write out the history physical and everything. So computerization for the whole outfit took some time to do. This was one of the first things that came in.

DT: Changing tack a little bit...

RM: Sure.

DT: ...what were relations like when you were in the dean's office? What were relations like between the nursing school, dentistry, Public Health, and the Medical School both before the reorganization and afterwards?

RM: Ohhh. That's a good question. [pause] From my perspective—this has to be from my perspective—it seemed as though the dental school was relatively independent. They were *all* relatively independent. They had their own deans. I think Dean [Erwin] Schaffer, who was the dean at the time, was a good dean. I think he was a very good dean. He, I would think, could sit down with Bob [Howard] or anybody and work things out. The dean [Gaylord Anderson] of the School of Public Health was an old timer who had been there forever and was very highly respected. It's hard to see that anybody would have... That would have been worked out amicably. The School of Nursing, I don't remember very much. They just didn't seem to be there very much. I know Bob met with them and so forth, but I never had much to do with them. So this is strictly from my perspective. I think the relationships seemed to be pretty good. I suspect that the concept of the health sciences was something that Bob was working on for a long time, and maybe what I saw was already the idea of getting together and talking and working it out, this sort of thing.

DT: It seemed like with the reorganization and the expansion the emphasis was on having more interdisciplinarity, more conversation between schools.

RM: Yes. Like I said, I think that one method of doing that was through the development program. You had to work with these people. There was a pot and you had to divide the pot. I think we worked pretty well together, as a matter of fact, and the faculty seemed to work pretty well together. There probably was fussing. I'm sure of that. The dentists had a big pot, so the dentists, remember, had, in some respects, the support of the basic sciences because they serve both, you see. So they had another group supporting them. The basic scientists, of course, were primarily with the Medical School, but they had a lot of involvement with the dental school. I think they would be a support, kind of, a little bit off-setting, for the medicine people. I don't remember any great feuds or anything like that. If there were, they were settled at very high levels. For all I know, they were settled there right away.

DT: Yes.

[laughter]

DT: I just remember another question I wanted to ask you about. Given that you were so involved with the planning of the expansion, what was your relationship like with Elmer Learn's committee, the committee for...[Committee for the Study of Physical Facilities for the Health Sciences]?

RM: Yes. I got to know him reasonably well. That's an interesting question, because the central University, obviously, had a big stake in all of this. I knew the head architect of the University [Winston Close]. I knew him from other circumstances. He was a fine violinist. I knew him and I knew his wife, who was a fine cellist. The Central Administration hired the architects. The vice president for Academic [Affairs], [William G. "Jerry"] Shepherd, was *very* instrumental in keeping things on an even keel at the highest levels. I'd see him around reasonably often. I think this whole thing was high priority with him. Elmer,...I think, that went pretty well. I thought that went pretty smoothly, but it was clear who was the *boss* when it came to certain things, like hiring the architects, and who did what with the architects. Of course, the architects to us were always kind of a pain, I suppose because they'd come in with these you've-got-to-decide options, and who likes those?

[laughter]

RM: There's this set of plans and this set of plans. This one does this. Now, which one do you think we should have? Well, more fussing. We can give hundreds more square feet to this department, but it means we have to cut fifty here and fifty there. Which one will it be? Well, you know, you don't like those guys.

DT: [chuckles]

RM: Actually, they were very good guys. We got along well.

DT: But, again, it gets to that space issue.

RM: That's their job.

DT: Yes.

RM: When it came to the technical stuff, their design, I don't know about that design of that slab of concrete. I don't know whether that would have been the best design in the world or not. Well, I guess that looks okay.

[laughter]

RM: It was really the *innards* that you were concerned about.

Elmer Learn—I haven't thought about him in a long time—I think at first was more involved. Then, as things went along, he was less and less involved as the architects... We had a guy [given and surname?] from the front office whom I worked with from up there—I think Elmer Learn was gone by that time—that I worked with, for example, on that rental thing with Najarian's ALG program. He was the one who took care of everything. He arranged the sale or I forget whether it was a sale. I think we bought the place. He arranged it all. I knew all about it, but he took care of it, and I didn't have to

bother with it. He did all the University stuff and made sure it came up to University standards. I think that was what Elmer Learn was really concerned about were the standards, that it would come through the standards of the University, especially in the infrastructure. I'm trying to remember... I thought he was very knowledgeable. That's all I remember about him.

DT: In 1970, right around the time I guess when Bob Howard resigned—it was before Bob Howard resigned—there was the External Committee on Governance and Structure, an external committee that was brought in. Did you have much relationship with them?

RM: No. I remember that committee. [pause] That's something you'll have to ask Bob McCollister about. I have an idea he knows more about it than I do. I'm trying to remember who was on that committee. Do you have any names?

DT: Ed [Edmund D.] Pellegrino chaired it.

RM: Ed Pellegrino was chair; that's right! Yes, yes, Ed Pellegrino was a big shot in the AAMC [Association of American Medical Colleges]. I think he was president or something, past president at the time, a very thoughtful guy, a good guy. But the locals, who were some of the locals?

DT: I don't recall, actually.

RM: If I remember correctly, there was nothing... They came and said, "Yes, I think you should make the Health Sciences. This is the current trend. This is the way it ought to go." Yes, and I think that's the way everybody has gone, pretty much. Whether it's good or bad, I don't know. You'd have to ask somebody who really understands all those things. There are probably, like everything else, pluses and minuses.

DT: Yes, sure.

I just have a couple more questions.

RM: Sure.

DT: I'm interested in your experience... You said you were involved with the human volunteer policy.

RM: Yes.

DT: Would you be able to elaborate on that experience a little bit?

RM: Not much. It was a faculty committee drawn from various people in the University. It was an all-University committee. I have no idea how I ended up on that. Probably Bob Howard suggested it to somebody. I think there was an administrator associated with it, who handled a lot of the administrative stuff. Then we had a committee and I think the

committee was strong from the health sciences, obviously, and probably stronger from the Medical School, because they were the ones who would be doing most of the research. It was health sciences mostly, but it was all-University. We didn't meet very often, and, lots of times, there was a lot of discussion about these things. This was all new. It was not nearly as defined as it is today. We were really kind of maybe even setting local policy by example. We did *not* have a lot of work. I don't remember that we were doing a lot. Maybe I got out of it. It seems to me that was late, before I left, in my time there. There was a lot of discussion in these meetings, a lot of talking about what we ought to do, the whole bit of patient rights and responsibilities of the investigators, what's the administrative thing that you have to set up for it. It was only in later years when I went back and looked at it and saw what it was like that I thought, oh, boy, glad I wasn't involved with it all that time. I think in most places, it runs pretty well.

DT: Yes.

RM: But, in those days, it was kind of what are we doing? How are we doing this sort of thing? We had some good discussions, but that was all. I think we approved some people and that was all. I have no records that I saved. I have no idea...probably because it was an all-University program and the records were not mine.

DT: Obviously, there was a lot of federal attention on the issues of [human] experimentation.

RM: Oh, yes. Yes.

DT: Yes.

RM: The usually expected tensions. The investigator who wants to do something and who has, perhaps, limited, good intentions but is limited by the rules and the laws. Most of the time, it seems to me, we worked it out. It was new; it was early. I'm not sure I even should have included it. It was really not much of an experience when I think about it.

DT: I think you said you were on that committee in 1972 and 1973 and, then, you left in 1973?

RM: Something like that. I can look in my CV [curriculum vitae] to see if there's any difference.

DT: I'd love to get a copy of your CV.

RM: You would?

DT: [chuckles] The archives like to have it.

RM: The reason I referred to it is because it's one of those CVs that goes on and on.

DT: [laughter]

RM: It was a way for me to kind of remember things, you know. All right, let me look here. [pause] I was on a bunch of stuff that I really don't know what I was doing. You'd be picked and the dean would say, "Who's there from the dean's office?" Ah! have Bob do it. No, I haven't even listed that, so maybe that was just so short that it wasn't hardly anything. Oh, yes! All-University... No, that's different. That was the Animal Control Committee. Some of this stuff was just... I don't have that.

DT: Interesting.

RM: Maybe I'm going to have to take that out. I did do it, but it maybe was just so short that I...

DT: Even if you did it, it's very interesting, just your recollections of it.

RM: I don't really remember it. [pause]

Okay, what else?

DT: It seems that during the 1960s and chiefly during the 1970s the U really began to be committed to increasing their recruitment of minority students to the Medical School.

RM: Yes.

DT: Do you recall much about that or were you...?

RM: Oh, there was a lot of interest, especially in American Indians, a lot of interest in American Indians. Again, Bob McCollister could tell you more. The other dean we had, Al Sullivan [W. Albert Sullivan]... Oh! I forgot about Al. Al's been dead for some years now. Al Sullivan was a surgeon who was head of Admissions. He was the dean for Admissions and ran that Admissions Department for years a long time after I left and before I got there. Al was interested in doing that. I know there was a lot of interest in getting American Indians, and that was difficult. They worked hard at it, and I think they still do. I think they still do work hard at it. Now, I don't know...there are other minority programs I suspect, but there weren't as many Latinos here in the state as there are now and there certainly were not many of the other immigrants, the Far Eastern or the African immigrants that there are now. The American Indians were *always* of concern, because they were, obviously, indigenous to the state. They were underserved. It was difficult; getting them to the point where they had the requirements met for the Medical School was difficult. But we had some go through. There were more and more minorities. Was there more emphasis on women? I don't know. By that time, it seems to me, that was... There weren't as many applying, but I think there was no problem then. I went to medical school in the 1950s and we had about 16 women in our class. I

know there would be more here in the 1970s. I don't know that there was an outright attempt to go after them. I don't think so. But there was work with Indians and other minorities. Like I say, I don't think there was quite as many other minorities around. *Now*, in more recent years, I think there have been more. Until I retired from the U, I was on the Scholastic Standing Committee and got to see the students from the other side.

DT: Yes, sure.

When did you retire?

RM: I didn't ever really retire from the University. I shouldn't say that. I quit the committee.

DT: Okay.

RM: I'm classified as emeritus, but I never wrote them a letter. They just looked at my age and how long I'd been there, and said, "He must be emeritus."

DT: [laughter] That's nice.

What was the relationship like between the clinical and the basic science departments? You've mentioned this a little bit. I know that the College of Biological Science was established around 1967?

RM: Yes, and they were part of Bob Howard's outfit. Well, I think they were probably typical of medical schools. I know they still exist in other schools, because I hear about that. I don't know how it is over here. I think it always has to do with several things that are universal. I don't think it's anything exceptional at Minnesota. Number one is distribution of resources. Number two is time in the curriculum. Do I have enough time to teach physiology? Number three is the graduates don't have enough knowledge of basic sciences, which is part of two. I think it's universal. I don't think it's any different. I've talked to people at other medical schools, and it's the same thing. I think it's built in.

But, I must say that the basic science directors, department heads, were always there fighting for their disciplines. They were very strong advocates for their departments. At least three or four of them, I remember very explicitly as having many confrontations. [chuckles]

I think all in all, we probably did reasonably well with the program, to get them space. They got some nice space. But, you know, that's a long time ago. I don't know how it is today. Like I say, I think that was pretty much the way it is everywhere. They're part of this massive undertaking, multi million, million, million dollar... They are not heavily financed from the state and from the feds. I think one of the pushers with the programs is to get research space for them. Strong advocates...they had *strong* people in their basic sciences, I mean really strong people: Wally Armstrong in Biochemistry and what's his

name in [Microbiology]... I forget his name [Dennis Watson]. He was awfully good. There were three or four of them. Oh, Ellis Benson. You probably have talked with Ellis.

DT: I've met him, and I'm looking forward to meeting with him.

RM: I would guess that Ellis has probably as much information today as anybody who was not in the dean's office.

DT: Okay.

RM: Ellis has a tremendous knowledge—or should have. He was involved in many, many of these things. His department was in between. It was Pathology, and he built up a very large and strong department. Pathology previously had a strong head, too. What was his name [James R. Dawson]? It was a strong department. They didn't sit at the back of the room. They were out there hustling for their needs. I think probably we weren't too bad in the scheme of things, probably not as nice as they would have wanted it but not, probably, as bad as it was somewhere else.

DT: Sure.

I just have two final questions and, then, anything else you want to add... These are kind of more general about your thoughts on things. I'm wondering in general what changes you observed in medical practice and medical culture during your tenure both at the U and just more generally in your career.

RM: The usuals. The technology race. The internists and how they operate. When I started off, I worked under the philosophy of C.J. Watson, Cecil Watson. Cecil Watson was one of the pillars of the Medical School, along with the head of surgery [Owen Wangenstein] and the head of physiology [Maurice Visscher]. There were a few others, but they were the real pillars of the Medical School. That was about it. It was a small medical school faculty before Bob [Howard] got there. C.J. Watson felt that internists were the well-trained and they did things a certain way. These were the thoughtful physicians and so forth. That's the way I was trained, a lot of emphasis on physical examination and research, looking into the literature, and this sort of thing. But that all changed. So now we have all these sub-specializations of internal medicine. That's been a *big* change, a big change.

I remember a meeting that Dick Ebert had. Dick Ebert was on the national Internal Medicine Residency Planning group. He got a meeting of all the faculty from Internal Medicine, and he told us about the changes. He said, "What we're going to do is we're going to have Internal Medicine go two years, and, then, you can swing into the specialties, and those are three or four years." Our immediate question was, "How many are you going to have of all these specialties?" He said, "I wouldn't worry about that. There won't be that many coming out of this unless we provide more specialization for internal medicine." I know a couple of us stood up and said, "Well, you know what's

going to happen. Internists like to climb mountains, and they will all climb those mountains.” And that’s sure enough what they did, sure enough what they did. I want to be a cardiologist. Okay! Bango! You looked for a fellowship, and you became a cardiologist and then practiced. Meanwhile, your internal medicine training didn’t fall by the wayside. Hopefully, it was with you, but you were *not* doing general internal medicine. So general internal medicine then became a problem in how to resurrect it, how to bring it back... So we had this go from general internal medicine to super specialties and now trying to get back to general internal medicine, how to get people back into that. It’s been *very* difficult, I think mostly because of the pay, salary, differences. So that’s a change that I saw that was quite remarkable. It happened at Minnesota. It happened all over the country.

Then the primary care business. I think the need for geriatrics, which I felt very strongly about, which has not been recognized yet, but will be. That, I think, is coming. That, I thought, has been a very important thing that’s been neglected, training people to do that. We need more geriatricians. Most medical schools have been very reluctant. They don’t see the research and the money. I think that’s why—or maybe they don’t think it’s worthwhile. I don’t know. It could be the geriatricians haven’t sold it. Mostly, again, the super specialization all over the place, along with the technology and the fact that the generalists have to spend so little time with patients. That, I think, has been kind of a change. The *demands* on the generalists to make money in order to get a reasonable salary is a very difficult area. That’s a change. [pause]

Well, the rest of the stuff, I think we all know. It’s got to do with the people fussing in Washington [D.C.] now about things, you know. We talked years ago...there was all kinds of talk about having a department in government that would look at new technology. When Medtronic wanted to put out a new something, they’d have to go there. Was this necessary? Is this going to be too expensive? We talked about that. Now, we’re talking about doing that. The stuff that was in ...when [Hillary] Clinton...it’s all resurrected.

All that stuff was talked about. People would sit down and say, “Well, geez, they’ve got all this new stuff coming out. Good Lord, do we need to do that?” It’s just like they’re asking now, only, now, we do it in spades. Before, it was mumbled. There was a lot of discussion then, a lot of discussion. I think that was included in Hillary Clinton’s program. A lot of that stuff was just stuff that we’ve all seen.

I suppose the other new thing that I find worrisome are the practice guidelines, that sort of thing. I’m a little nervous about that.

DT: Why? Why?

RM: Well, because of the handling of exceptions. That’s all. If the exceptions are being handled appropriately, I’m not worried about it. But if it becomes too bureaucratic, then people will get in trouble. The typical example is the patient who has high blood pressure, and if you give him too many of his blood pressure pills, he gets hypotensive,

and he faints on you. So you can't get his blood pressure down to 120/80, so you get it at 150/90. All right? That's not what's required, you know. So someone comes through and says, "Doctor so and so can't get that patient's pressure down, so we're not going to pay him," or something like that. I don't really see that happen, but you could see how it might. That's the kind of thing where the individual kind of gets lost and it becomes cookbook medicine.

One of the *greatest* studies though—no doubt in my mind—has been the studies out of Dartmouth [The Dartmouth Atlas of Health Care] of the difference in payment and the difference in quality in the country. I think they have been fabulous studies. Those have been really eye opening. Minnesota has done well. We usually are not too expensive and we usually have pretty high quality, as does most of the northern tier of states. I feel sorry for the people in the South. At any rate, these studies, I think, have been *really* eye opening, wonderful studies.

DT: Any final thoughts you have?

RM: No, I'm thought out.

DT: [laughter] Well, this has been fantastic.

RM: Really?

DT: Yes. There's so much information here. I'm looking forward to reading the transcript. You've been a really good storyteller, so I very much appreciate your time.

RM: Thank you. I tried not to be too judgmental. People take stands on things, and sometimes you can be critical of them and say, "Well, da, da, da, da." But, you know, when you look at them in time, you say, "Well, maybe he was right," or "She was right." The leadership at the school, for all of the fussing and everything else, during that period of time was pretty good when you think about the results, in all of the ferment that was taking place and all of the challenges. Duluth went through a thing and now it's part of the Medical School here! I don't know how that happened, quite frankly. They probably realized it was difficult to be a free-standing school. Besides, they're down there; we're up here. We'll do our things like we always do. We fussed about the affiliated hospitals. I don't know how well they're doing, but they're there in a tough environment. So, I think, in retrospect, a lot of the decisions that were made and how they were made, even though they were sometimes very contentious, hey!... Who knows? The Medical School is still here. It's still a great medical school. It still churns out many good students, lots of good students. I'm proud of the Medical School.

DT: Thank you so much.

RM: Yes.

[End of the Interview]

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