Vincent Hunt, MD
Narrator

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Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

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

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

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

Interview with Vincent Hunt

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at 510A, Diehl Hall, University of Minnesota

Interviewed on February 9, 2010

Vincent Hunt - VH
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Vincent Hunt. It is February 9, 2010. We are in my office at 510A Diehl Hall, University of Minnesota.

Thank you, Doctor Hunt, for joining me today.

VH: I'm happy to be here.

DT: Just to get us started, perhaps you could give me a little background about where you grew up and where you did your studies and how you got into medicine.

VH: I grew up in Northfield, Minnesota. Then, we moved to several towns, and I ended up graduating from Anoka High School. So everything has been in Minnesota from that viewpoint.

I went on to Saint John's University in Collegeville [Minnesota] for my pre med, and then came down to the University of Minnesota for medical school in 1956 and graduated, then, in 1960.

I interned at Bethesda Hospital in Saint Paul and practiced in the rural community of Red Lake Falls up in the northwestern corner of the state, a town of about 2,000. We had a twenty-five bed hospital. Much of the time, I was the only doctor in the county [Red Lake County]. I mention that because I think so much of my subsequent experiences here at the University of Minnesota and elsewhere relate to that formative experience of

working in this rural area where you really got to know the patients and you got to know the environment in which they function and how that impacted health and disease. I certainly saw the effect of poverty—I think this was the poorest county in Minnesota—and also saw the value of community mobilization for a variety of projects.

For instance, when we had a bad snowstorm that lasted for three days and we couldn't get around, somebody loaned me a snowmobile to make house calls and calls in the hospital. The Rural Electrification Association donated a large machine that they use to go out into swamps and bring telephone poles. It had tires on it as high as me or, perhaps, even higher and it could go right over snow banks and pick up farm women who were in labor. Or if somebody got shot with a deer rifle or something and had a lot of bleeding, people would come *immediately* by word of mouth, practically, to come and donate blood. So you saw the whole spectrum of health and disease and the community working together.

In 1969, the University of Minnesota had a grant from the American Academy of Family Physicians to train five doctors who had been in practice between five and ten years and help prepare them for this new movement of family medicine. So I came back as a resident in that innovative project.

Then, from there, I went to the Hennepin County Medical Center, which was my first position, in the academic world, so to speak, and was, then, offered a position as director of the Family Medicine Program at Saint Paul-Ramsey [Hospital]. Let's see; that would be 1971. I was there until 1985 and, then, in 1986, I went out to Brown University [Providence, Rhode Island] to chair their Department of Family Medicine.

DT: I, obviously, have some follow up question on that, but one of the things that I will want to return to in a little while is your timing or practice. I'd certainly like to hear more about that. Before we focus on your time as a medical student, perhaps you could tell me why it is you went into medicine.

VH: [pause] Hmmm. It was kind of serendipitous. I had a scholarship to go to the University of Minnesota and prior to that had come down and did all these tests. This advisor suggested that I become an engineer. I thought I'm not sure that's what I want to do. I'd like to have something to do with people; yet, I like the idea of science and those kinds of things. When I got to Saint John's, I had started late; school had started. They gave me an advisor who spent a little time with me. I told him I'd like to have something to do with people in maybe psychology or something like that. He suggested that I think about pre med, take a little pre med.

At the time, the president of Saint John's had talked to my older sister who had talked to him about me coming there, and he said I could come, but I didn't have any money. I only had twenty-five dollars. So I went to the bursar and he asked me how I was going to pay for this. "I don't know," I said. "I've got this money ($25)." He checked with the president to confirm that I could stay. At that time, I thought this is not too good, so I actually quit and went home.

I talked to my dad who, then, suggested, "Why don't you go back, and if you don't know for sure what you want to take, take a mixture, some history, some other subjects, and science, and see how it goes? Then you can make those decisions down the road." That gradually happened. It became more and more clear that that's what I wanted to do. I think it was like this for so many people, it combines a humanitarian instinct with the scientific and probably trying to understand the really interesting aspects of biology and physiology and human nature, as well. So it's a combination of all of those things. My role models had been general practitioners, and I kind of looked upon that at the time as the field, probably, that I would want to go into.

DT: That's quite different from some of the impressions that one gets from looking at medicine in the 1950s and 1960s where the general practitioner wasn't viewed as highly, or certainly by academics.

VH: Yes, that's right.

DT: Do you think it has something to do with growing up in a smaller town, that you had more contacts with general practitioners?

VH: I think so.

DT: Can you tell me what your experiences were like being a medical student at the University in the late 1950s?

VH: Well, I've been thinking about that since I knew I'd be coming here. It was just a very exhilarating time, and, yet, also, it was mixed. The exhilaration, of course, anybody would have in terms of going into medical school. Yet, I think it was extra special at a place like the University of Minnesota, because I think there was a sense there that in so many of the disciplines, we were on the verge of all kinds of interesting break throughs. It was just a very wonderful time, because you could see that there were things coming, especially, of course, in surgery and cardiac surgery. I think Wayne… What was his name who described…? *King of Hearts*. G. Wayne Miller wrote this book, *King of Hearts* [: *the True Story of the Maverick Who Pioneered Open Heart Surgery*]. I think he captured that excitement of what it was like, and we were right there. All the people like Norman Shumway and Christian Barnard were around, and, of course, all the people that were here at the University. I think it also extended to other fields as well, not just surgery. There were some pioneering efforts in lots of areas, in oncology and in psychiatry and pediatrics for sure, and probably many other disciplines. So that we had, and I think it rubbed off on us. It was kind of like a sense that maybe this was one of the most advanced medical schools in the world. That's really very nice.

On the other hand, I think that the downside was that coming especially, say, from a liberal arts school—I had a double major in philosophy and natural science—I was exposed more to things like ethics and those kinds of concerns, and the whole idea of the dignity of the human being that have a long, interesting history of how we ever got to that idea that the human being had intrinsic dignity.

During this time, I think there were experiments or experimental approaches to patients that probably would not be accepted nowadays. I think some of us sensed that and felt caught in between the excitement and the realization that some of this might be necessary in order to advance society, but, at the same time, I think we felt considerable concern for some of the patients. I think that was also reflected in Miller's book. I think he captured that as well and talks about some of the debates among the doctors about whether or not to do one or another procedure. As a medical student, you're not in a position to question too much. Most people said…The slogan then was if the wall is green, turn green. Don't stand out; just do your job and get through with it and get out.

I don't think I ever resolved that dilemma because I could see both sides of it.

Another thing, I think too, is that the importance of research probably took precedence over teaching. I think coming from this small liberal arts school where all our teachers were basically Ph.D. people and very interested in us as students… I didn't get that sense coming to a big school. I think that's just, perhaps, inherent in the school, in any big medical school. But I wonder now in retrospect if, perhaps, we'd had more of a feeling of collegiality or whatever it might be called that maybe we could have transcended that a little better. I think there's a lot of awareness of that now.

We certainly had exceptions. We had people we could always go see, like Dean [H. Mead] Cavert, who was the dean assigned to us. Anytime we had any questions, we always knew we could go visit him. Al Sullivan [W. Albert Sullivan], who was around in surgery, he was just very supportive to students, and certainly many other teachers. There was a Cy [Cyrus] Barnum who was a wonderful teacher, and I'll get to Dick [Richard] Magraw. I'm sure we'll want to get going on that.

Another great influence for me was somebody by the name of Carl Alexander, who was a cardiologist and researcher out at the VA [Veterans Administration] Hospital. I got a position working for him during my junior and senior year, helping him with his research, much of it related to nucleic acid metabolism and working to try to elucidate the cause of what they called aminonucleoside nephrosis in rats. The were developing an antibiotic called Puromycin… They couldn't give it to humans because it caused nephrotic syndrome in the rats. The idea was to try to find out how this was working and maybe you could do something to help human beings as well. During our Christmas vacation; we had a couple weeks, and he told me to go to the library and read all I could about this subject and, then, come up with a plan how we could pursue it. As a junior medical student, that was quite a wonderful experience. I worked with him for two, three years, even into my internship on some of these things. He always treated me with great respect and collegiality.

I think I learned from this experience another important value that lasted, I hope with me all the time: the importance of being very critical, a critical approach to literature and to whatever you're doing and care for your patient with that same manner of not being the

first to jump to some new treatment or drug and having kind of an intellectual rigor and approach to this.

So it's hard for me to be critical because I see all the good things that came, too. But, there was that one nagging problem, and I think, perhaps, that might have been the times rather than necessarily the Medical School.

DT: Yes, the ethics around clinical research were quite different then. It was only a few years later that ethical standards were introduced to human experimentation. So it's interesting that you and your student colleagues were experiencing some kind of tension.

VH: I think so. I think so.

DT: Do you get the sense that the faculty were also toiling with this issue around ethics?

VH: Hmmm. I'm not sure. I don't think I knew them that well to know that.

DT: As a medical student, you're not really exposed to…

VH: I think I probably had discussions with Doctor Alexander about this because we were quite close. I'm sure that we had some discussions about this, but I can't remember [unclear] with the other…

DT: You mentioned that perhaps as a consequence of all the focus on research that there was, in some cases, less focus put on teaching. I wonder, do you have any recollections about the different kinds of teaching styles that certain faculty members would use?

VH: Yes. Like Cy Barnum, when he taught, you just had the feeling he organized his data so beautifully and presented it so well, even though it was often complex, and he always made himself available to students. As I remember anyway, if students had any questions, he would be there for them, even in the evenings. I think some students spent time with him in the evening. There were many, I think, like that; although, he was pretty exceptional.

There was also a feeling of kind of eliciting fear in people and that you better learn this or you're not going to make it or that, maybe, you'll get sued or whatever it is. There was a lot of that that went on. That was, again, quite different from what I was used to in my undergraduate years, which was kind of a cultural shock.

There was one doctor, A.B. Baker…everybody talked about him, you know.

One of my classmates, he made him cry. He just kept at him and at him. I heard that from many others, too. It was kind of an abuse of power. I think the one thing they did teach us that maybe some students don't always get, in my experience with other doctors, is that… I think we were taught by that that medicine is a very serious situation, and you

have to be sure of what you're doing when you're caring for patients. I think that was something that, perhaps, that approach instilled in us.

Then, there were in-betweens. The doctor on surgery, Alan Thal, who came from South Africa, I think… He would make rounds with a group of students. Maybe there would be eight or nine students or ten. Of course you were on edge because you were supposed to present your patient to Doctor Thal. You were always worried. You wanted to be sure you did a good job. Anyway, one student presented the patient, and this patient was a state legislator who had something to do with allocating money to the University. Doctor Thal didn't think he presented adequately. He asked him [the student], "Where is the pain?" He said he had pain in his right upper quadrant. Doctor Thal objected. He said, "You say just pain This was excruciating pain and only a person with great moral fortitude could stand this kind of pain," something like that. He made it really into a big deal. I happened to be just standing right next to the head of the bed, so I leaned down and asked the patient if that pain was that much. The patient could see what was going on. He said, "No! It wasn't that much."

[chuckles]

VH: So then Doctor Thal saw me talking to the patient and asked me what we were talking about. So I told him, and I think you could have heard a pin drop in the room.

Nobody said a thing. We all walked out and, then, he got after me and said, "Hunt, if you think you're so smart, you're going to have to scrub in on every surgery I do for the rest of this clerkship. You better know what we're doing," or something like that. So I did; I scrubbed in on every one of the operations. Actually, it was a pretty good experience, because I got a lot of individual attention, and he recommended a book, Sir Zachary Cope's book on the acute abdomen [*Cope's Early Diagnosis of the Acute Abdomen*] to me, which was one of the finest medical texts I've ever read. I took it with me to the rural practice. So it didn't turn out all that bad, but it's an example of the kind of pressure you were under.

At the same, there was so much to learn and know. I kind of feel we missed the… I don't know how it's going now with today's medical students, but in the ones I worked with at Brown, I think it's changed. In a way, you still have so much to cover that sometimes you miss the beauty and the grandeur of what we're going through. I think that's too bad.

DT: Did you have much experience with Owen Wangensteen and C.J. Watson?

VH: I was on Doctor Wangensteen's service. When I went on internal medicine, Doctor Watson was on a sabbatical of sorts. We heard him for lectures and I thought they were very good. Doctor Wangensteen… We got insight into him, I think. I never had any direct relation like with Doctor Thal. [laughter] But I felt like I got to know how he was thinking and his questioning and dealing with the residents or the fellows and things like

that. I think that was probably the major service where the ethical issues became the most paramount.

DT: You said you went, basically, into medicine early knowing that you probably wanted to do general practice. Were there opportunities within your medical education to start specializing? I realize that things were quite different in the late 1950s, especially when it came to general practice. Did you have those opportunities?

VH: You mean, for instance, to apply for a specialty or something?

DT: Or did you have any opportunities to take electives or was all very regimented and rigid instruction?

VH: There were some opportunities to take electives, yes, during the fourth year.

I should say that one of the things that influenced me a lot was that I applied for the… At the time, there was a lot of concern about what was happening in general practice in the rural areas especially and legislators and such were involved. Well, the Minnesota Medical Association came up with what they called "A Rural Medical Scholarship." I don't think it was a true scholarship. It was given to one medical student a year and you had to apply for it and it was a competitive thing. You got $1,000 a year for four years, and, then, you agreed to practice in a small rural community for five years. If you decided not to do that, you paid them back the percentage that you hadn't used up. For instance, if you went for two years out of the five, then you paid them back sixty percent. I won that scholarship, or whatever we called it. So I pretty much knew I was heading out to a rural area in family medicine. So my mind probably wasn't as open to going into a specialty; although, I would say like most students, almost every rotation you go on, you say, "Oh, I'd like to do this."

[laughter]

VH: I think I had it in my head it could be that, after a few years of practice, I would try to apply for some specialty, but, then, at the same time, I think I got more and more absorbed in this. When we get to the Comprehensive Clinic, I think that really was what helped cement my thinking.

DT: Did you encounter any resistance or frustration from faculty members if they learned that you wanted to go into general practice?

VH: I don't think so; although, I never got any encouragement. I think there was always encouragement to go into their particular specialty. And there were all those comments. There were a lot of comments about the GP [general practitioner] that didn't know this or that. I don't remember feeling a sense of real support, but, at the same time, I don't think too many people knew what I was going into. Nobody tried to talk me out of it, except Doctor Alexander. He wanted me to go into some sort of research, and he was good

about it. He respected… He never spoke about it with denigrating the rural general practitioner. I think some people appreciated what it would be like out there.

I'd say the only negative was at the end of our surgical rotation. Doctor [Richard] Varco asked the students if they had any questions in a very friendly manner. "Now, we've gone through this. Are there any questions you'd like…?" I usually didn't ask many questions. But, I was worried about what do you do if you have somebody choking out in a rural practice, like where you need to do a tracheostomy? I asked him if he would give us some general principles or ideas of how to go about a tracheotomy. He just chewed the heck out of me saying that, first of all, "It's a trache*ostomy*, not 'otomy."

DT: [chuckles]

VH: Then, "You have no business doing that." The same thing happened, I think, a little bit on OB [obstetrics] where there did not seem to be the awareness of what it was like when you were out in a rural practice, say, in the middle of a snowstorm and patients can't be referred anywhere, and if you don't do a C-Section or something, the patient is going to die, or say a hemorrhaging obstetrical patient. There was never any real, as I remember, emphasis on what the rural GP should be doing out there, especially if you didn't have an obstetrician right next to you to help you. So I would say from that viewpoint, it wasn't enough to dissuade me, I guess, but it was enough for me to worry about being well enough prepared. That will get us into talking, too, later on, about the family practice residency.

DT: Right.

VH: One other quick thing about medical students. We had a Doctor Lemen Wells who taught us anatomy. He could write with both hands. He could draw the circulation with one and the bones with the other—I don't know how he could do that—with different colored chalk and all that kind of stuff. I wonder if there's ever any picture of him doing that because it was just an amazing phenomenon. He loved to play handball and had a handball court in the basement of his house. He invited anybody, any of the class, to play him in handball, so we did have some interactions. I took him up on it. The first game, I happened to beat him. He got so upset.

[laughter]

VH: He really was upset. So the next game—he wanted to have another game—I made sure I didn't play quite so well, and he beat me. So I left with him being happy. That was kind of a funny episode.

DT: This will likely get us into the Comprehensive Clinic, but as I understand it, there were some curriculum revisions that were made—however, it must have been right at the end of your time in the Medical School, in 1959, 1960—particularly with an eye to increasing students' clinical experience. Can you talk a little bit about that from the perspective of being a student and this effort to get more clinical exposure?

VH: I should have said that we were also sensitive as students that there were these curricular changes going on and that some people put a lot of work into that, and I think we all appreciated that.

The thing that I remember is that they didn't want us to be aware of exam grades, so, basically, we never knew our grades during those first two years or any of that time, I think. That was an idea that we would be freer of competition and concentrate on patient care and learning. I'm not sure it worked quite that way, because I think students worried. Sometimes, it would be better to know, perhaps. I guess I shouldn't say that because scores would be posted sometimes [primarily it was "pass" or "fail" rather than a comparative grade]. Sometimes you might get a comparative, but I can't remember that too well. The idea was not to be competing on that. I think somebody thought that through. The third year, we didn't have many exams until the end of the year for the rotation, again, with the idea of just try to take good care of your patients and learn and that will take care of itself later on. I think those were good ideas. In the fourth year, you had more rotations into the various subspecialties. I don't remember whether we benefitted from some of the subsequent changes along those lines. We were probably in the vanguard of some of them. I think most of us appreciated the fact that the Medical School and all the time that had gone into that.

DT: It seems that the Comprehensive Clinic sort of came out of that push for advanced medical students to have more responsibility, more clinical responsibility. Can you talk about the creation of the Comprehensive Clinic and, then, your experience going through that?

VH: Well, what I remember is that we were told they wanted to set up this Comprehensive Clinic, and they asked for four [correctly, three] volunteers to be kind of guinea pigs of this. So I and three of my classmates volunteered for this. We, of course, didn't know what had gone on in the past or any of those kinds of things, but we knew the basic goals of this, the idea that it would be close patient contact. You'd follow the patients from the time they come in to all the different specialty areas and, then, get to meet with the various specialists, consultants, and, then, put together the medical report back to the referring physician with a lot of input then from all the other people to make sure it was right. We kind of had an idea of what it would be like, but nobody really knew. We met with Doctor [Richard] Magraw. He explained it to us. Well, we thought we would give it a try. I think it was a three-month rotation or something like that. It was just a very gratifying experience. We got to know the patients quite well, and I think the patients appreciated it.

There were a lot of advanced educational ideas there. I just thought about that on the way driving in here today. For instance, we had group learning experiences where we would all get together and exchange ideas. Doctor Magraw would lead it, would ask us questions. It was also an interactive learning experience between the teacher—in this case, Doctor Magraw—and the students, but it was in a collegial format, some of the things I was mentioning before. It was a comprehensive approach because you paid

attention not just to one item for that patient, but you were trying to look at the whole patient making sure that the full picture was addressed. So we had those.

Another one was problem-based learning. It was almost the ideal problem-based learning because it was based on the real problems of the patient, and it was up to you to pull it together in this letter, which was very important to the patient and the referring physician. Also, you had the contact, because that letter wasn't going to go out if it weren't accurate, so you had a check and balance of your own learning experience by making sure it went by the appropriate people for clearance.

There were all kinds of very basic educational approaches that I think they are still talking about in terms of almost as innovations.

We were using them without even knowing it at the time.

So we would report back, and he would take our experience to kind of refine the experience for the ones that would follow us. It really filled a need or a gap for us in our learning, and I think it really cemented my idea of what I wanted to do as a physician.

DT: Do you recall the names of your colleagues who were also went through the Comprehensive Clinic?

VH: I remember two: Doctor Al [Allan] Johnson and Al [Alvan] Gendein. I don't remember how to spell Gendein. Those are the two that I remember. I can't remember the third one. I think there were four of us [correctly: there were only three]. Al Johnson just passed away about a year ago.

DT: Ohh [spoken softly].

VH: I don't know about Doctor Gendein.

DT: You four were the only ones going through it, so you, obviously, were still in touch with your other colleagues. Were they envious that you were getting to do this? What were the attitudes of the students, do you think?

VH: You know, I can't remember whether they paid much attention to what we were doing or not.

I can't remember whether there was a general appreciation of that or not. I don't remember anything negative at all. I think the four of us thought it was a great experience. But I can't remember the attitudes of classmates.

DT: Did you get any sense of how, maybe, other faculty felt about the program?

VH: The only sense I would get is when we went around and presented the patient to, say, Doctor Yang Wang. He was a wonderful cardiologist. That just really stands out in

my mind, because I remember how fortunate I felt to present the patient to him and, then, to be there when he did all the examinations. He explained everything to me and we went back and forth. I had the feeling that every one of the people—at least I can't recall any others being negative—those people to whom we presented and followed the patient and all of that and saw the *value* of this for the patient., were supportive, the consultants that we saw. I don't know what the others felt about it.

DT: Was it just Dick Magraw or were there other faculty involved with running this?

VH: I think there were, but I can't remember. I just remember him mostly. There must have been others.

DT: He was the one actually in charge of the [Comprehensive] Clinic.

VH: He's the one I remember who would get the data from us in terms of suggestions for the future, and he's the one I remember we felt was certainly overseeing the whole picture.

DT: When I met with Doctor Magraw, I was astounded by his broad arrange of training that he had done. He had these three specialties that he was changing.

Obviously, he manifests this idea of practicing comprehensive medicine. Did you get a sense that he was unique, perhaps, because of his training and his perspective on patients?

VH: I think so. I think we did, yes, and, yet, he was inquisitive and still learning. I had that sense. I don't remember him ever preaching. I think he let it evolve as we saw the patients and then the questions. Like asking about the patient's lifestyle or whatever it is, that brings it out without necessarily preaching how important that is. I don't remember him like on a bandwagon, "This is the greatest thing," or anything. Basically, he had the idea, and he wanted to perfect it well, and we were partly his colleagues in that effort.

What was that you asked?

DT: Just did you get a sense that his perspective was a little different.

VH: There was no question about that. That's why I felt I resonated with that in a way that so many of the other specialists are pretty narrow—not that it's bad, but they're pretty focused and reductionistic in their thinking and here was someone trying to deal with the whole picture but not negating the importance of the specialists. It was quite interesting, quite an experience.

DT: It sounded, when I spoke to Doctor Magraw and hearing again from you, like just a great experience. It seems that it would be something that would be really beneficial to students, as you yourself found.

VH: Yes. It was labor intensive in a way, because, here, he was having to deal with us, and somebody had to review those letters where, before, you didn't… So I suspect that could have been a problem of time commitments that we probably wouldn't have necessarily appreciated.

The other thing is that you'd—I don't remember us going into this, but looking at it from my head as kind of a teacher and educator—probably want to be sure you weren't missing too many other experiences, because these were labor intensive where you're following a patient around. If you're on a rotation, all the people would have these particular problems, internal medicine or surgery or peds, whatever. So you were exposed, maybe, more in depth to these in particular, where, here, I might see somebody with cardiac problem, or somebody with a GI [gastrointestinal] problem or this or that. I suppose that would be something that could be criticized about it, but I think there are ways to get around those things, too.

DT: Just so I fully understand… The way in which the Comprehensive Clinic was so different from the other clinical rotations was that when you were on the other rotations, was it the case that students would just round with the attending and the residents and would have less involvement with the patients?

VH: Of course there are two different experiences here: ambulatory or outpatient, and the inpatient. Both of them, you kind of take whoever comes to you. You're assigned, the people who are in the hospital, and you're just kind of assigned different patients. You might have three or four patients or something like that you're assigned to and you deal with those people. In the ambulatory, it's the same way. You're there and when your name comes up, then you take care of this patient. This was an ambulatory experience, so it wasn't like an inpatient experience. You were assigned the same way…I think he may have had a way of trying to balance out our assignments so that we got a broader experience. But it wasn't a one-shot deal where you'd come in and you see the patient for a half hour or an hour, fifteen minutes, whatever, and then you don't see him again. It was, no, you're there, and you're following that patient through all these different experiences, and if they'd come back again, see them again. It was that continuity and comprehensiveness, which are kind of the foundations for family medicine.

DT: Yes.

VH: I think it's well described in his *Ferment in Medicine [a Study of the Essence of Medical Practice and of Its New Dilemmas*], Magraw's book. He doesn't talk about the Comprehensive Clinic as such, but he does talk about the doctor/patient relationship, and he talks about the influence of reductionistic thinking and the importance of integrating knowledge and pulling it together and the continuity and kind of the human interactions, those kinds of things. I think that this displayed those principles in a way that you didn't experience in the ordinary rotations, even in the outpatient rotations. You'd get that kind of reinforcement and exposure.

DT: This experience, I presume, must have served you well then when you went out into rural practice the first time. This is the kind of relationship that you would have with patients, presumably, in rural practice, in general practice more generally. Maybe we can spend a little time talking about, first, your internship at Bethesda and what led you, then, to make the decision to go into rural practice.

VH: Okay, sure. Could I mention one more thing about the Comprehensive Clinic?

DT: Oh, of course. Yes.

VH: I have written a note to myself that this concept now is still alive in different ways. It's probably alive in the family medicine approach in which they try to have a family medicine center and that you're assigned to patients in a continuous experience over a three-year period. It came to my attention about five or six years ago that the Harvard Medical School had an option for students where they have what they call a comprehensive clinic…

DT: Hmmm.

VH: … at Cambridge Hospital in Boston. There is a network now of about fourteen schools that have comprehensive clinics.

The University of Minnesota is part of that in their RPAP [Rural Physician Associate Program]. There are a couple in Australia, one in Canada, and different places, which was interesting to me. I went to see the one at Harvard. It was a couple years ago I stopped in there to see the students and see what they were doing. It was so interesting because they feel they're the pioneers in this.

DT: [laughter]

VH: Students take nine months or something like that during their junior year on this comprehensive clinic where they follow their patients around and do all these things. I thought that was interesting. So the spirit is still there and I think especially in terms of what we've tried to accomplish in family medicine.

DT: That's actually one of the things that I'm really loving as I do more and more of these interviews, particularly after speaking with Doctor Magraw, that so many of the innovations in medical education that were taking place at the University in the creation of the Family Practice Program and, as you said, the RPAP, the Rural Physician Associate Program, were innovative in the 1960s, but, now, as you say, they're still being considered as innovations in some other form. That's why history is so valuable, just to say, "These aren't new ideas." [chuckles]

VH: I've seen that now in my lifetime.

I've gone through quite a few cycles.

DT: Yes.

VH: I think it also, to me anyway, shows the influence of these forces that are so strong in society. No matter, sometimes, how hard you work, if you don't have a society that's supportive of it… For instance, the reductionist approach, we've had so many great advances because of that. But if we don't have a counter balancing horizontal approach and holistic approach or comprehensive approach, problems fall, and patients of course fall, between the cracks. I think we're seeing that tremendously now in society when we look at the mortality and morbidity of iatrogenic type problems in hospitals and things like that. I think a lot of it is due to the tenuous relationship with the patient and the fragmentation that has occurred. The forces are so strong that it's very hard to counter them. We came up in the 1960s during a lot of social consciousness that created a climate for family medicine to get its start. We haven't seen quite that same kind of consciousness repeated maybe, but we need that in order to grow and thrive.

DT: This is great. There are some things in what you just said that we'll return to when we get onto the Department of Family Practice.

So you did your intern year at Bethesda Hospital in Saint Paul. That hospital no longer exists.

VH: That's right.

DT: What kind of experience was that? What kind of patients were you seeing there?

VH: Well, I think a lot of people in those days, especially those that had this rural scholarship, had gone there. There were a lot of general practitioners in the hospital with most of the specialties represented. In fact, Doctor Ben Fuller would come over there at times as a consultant, so you had them. It was a chance, I thought, to get better prepared. I had interviewed in a lot of places even out East, places like that. Then I got to thinking I'm going into a rural area, and I'm going to have to know how to handle some of these problems, and I don't see how I'll get it in a year, and, in retrospect, it would be better to have three years like we do now, but, in those days, they didn't have family medicine residencies as such. I thought, well, these others went out from there and did well, and I liked the environment there, the atmosphere. In fact, Doctor Sam Hunter had done the first bipolar pacemaker insertion there a couple months before I started, so they were on the fringe of knowledge in some areas. I guess that was the reason and some of my friends were going over there, so I thought that would be the place to go.

DT: After you finished that year, you then went…

VH: Oh, one thing there is I got a lot of obstetrical experience. I delivered I'll bet you 700 or 1,000 deliveries. I had a tremendous amount of obstetric experience, which I was especially worried about in rural areas. I also got to do some procedures that I thought would be important when I got there. So I think, perhaps, it was the best choice for the

circumstances, and I did like the people there. We worked hard, but it was a supportive environment, and that makes it so much easier when you're working hard.

DT: From there you went to Red Lake River?

VH: Red Lake Falls.

DT: Red Lake Falls. Also, you said as part of this rural medicine scholarship you had you had kind of committed to going into rural practice. Did the Minnesota Medical Society help you find a place to go?

VH: They had a group of four or five doctors that would make a decision about where I would go.

DT: Oh, you didn't get to choose? [chuckles]

VH: I had a choice, but it had to fit their criteria. And I didn't know about that at the time that I got the scholarship. I didn't know how this would work.

The conflict was that I wanted to go to a place that had a hospital and that I thought would eventually support three or four doctors. This is a classic conflict between the young and the old in this case, because I could see that it would be so helpful to have others around when you needed them or if you wanted to go on vacation or take a day off. These people wanted me to go to a town without a hospital and without any doctor. Gosh! I had picked a few towns. It turned out that the doctor who was in Red Lake Falls was a lobbyist for the State Medical Association. During the legislative sessions—I think they were every two years for about three or four months—he was gone almost all the time to do his lobbying work and needed somebody to cover him there. He had kind of the political clout, so the only place they would agree that I could go that had a hospital was Red Lake Falls.

So I went there. There were a few other places where, perhaps, I might have preferred, but I probably would have never had the experiences I had up there. It's a tough way to learn, when you're all by yourself up in a little twenty-five bed hospital.

DT: What other healthcare providers were there? Presumably, you had a nursing staff.

VH: Yes, and they were wonderful, both practical and RNs [registered nurses]. This was run by Catholic nuns, Benedictine nuns. They would work night and day. I mean, if you had a critically ill patient, the fact that the shift was up had nothing… They were there to stay. They were really worn out, too, because they didn't have enough help. They worked hard and they were wonderful. I had great appreciation for what they did.

In the community, there were community efforts for different things, like various immunizations. We'd have big community immunization programs. Coronary units were starting. Hospitals were starting to at least have defibrillators and things. We had a

community drive to have our own little coronary care unit in those days and things like that. So you did have a sense of working with the community. Some of those things, as I mentioned, I probably wouldn't have learned.

DT: Were there public health nurses, as well, who were going out to patients' homes to do home visits?

VH: You know, I don't remember that. [pause] You'd think there would be, but I can't remember that. Growing up, I remember that in Northfield and places like that. I'm not sure. [pause] They were, I know in Crookston [Minnesota] working with public health nurses. I was in a neighboring county and I can remember some of that working with them. I'm not sure about our county. They were very strapped financially and I'm not sure they had much of that going on.

DT: My very limited understanding of rural public health nurses is that it was county dependent, depending on how much money there was. Where the public health nurses were going out to patients' homes, they had a lot more responsibility than their colleagues working in hospitals.

VH: Yes, yes. A strange thing when I think about it… In our clinic, we would ask our nurses to go out sometimes, too, and we never charged for that. [chuckles] Our goal was pretty much to break even at the clinic financially and our profit was in the hospital… It's just the opposite now. We charged three dollars an office call. I was the county coroner, and I think I got paid a dollar a year for that.

DT: Ohh. [chuckles]

VH: I'd go out on all kinds of circumstances, deaths, and things like that.

DT: When you were still out in Red Lake Falls, this would have been when Medicare and Medicaid were passed.

VH: That's right.

DT: Did that change your practice in any way?

VH: [pause] I know we were all very concerned about it and would go to the county medical society meetings. We had about eight or nine counties that were all together up there. Holy mackerel, everybody was predicting a dire end of the world, practically. We had a business manager and, at that time, I had another partner with me, somebody I interned with, and we just let him [the business manager] worry about it. I wish I could remember that. The only thing that I remember is there were some problems. We would often write off bills when patients couldn't pay for it, and Medicare had some rule about you couldn't charge them more than the lowest that you charged another patient. [Thus if you wrote off a bill for a patient, you were required to do so for all Medicare patients.] I think there were some problems with that. Again, it's funny that I can't remember us as

being… Like I say, we let our business manager worry about it, and we seemed to get through it okay.

I do remember how exciting it was when the child care… What was that that came out? I can't remember the name of it [Operation Headstart]. All children would get…the poor could get free examinations. It came out as part of this, I think. It was just wonderful, because you'd get all these children from poor families coming in that hadn't had much medical care. You could do a general physical on them, take care of them, get them to wherever they needed to go if their hearing was a problem or whatever, and get them immunized. I can remember being excited about that. I don't remember agonizing too much about it, but being pretty happy that now people had some sort of coverage that they didn't have before.

DT: Did you notice an increase in patients because, now, people were willing to seek medical care because it was covered?

VH: I never could sense that. It seemed like we were busy, quite busy, all the time. We were always struggling with a declining census in the hospital. That kept on going down, I think. I can't remember thinking this has caused a great increase in patients.

DT: So it wasn't the end of the world as the county medical societies has predicted.

VH: That's right, yes.

DT: I've done a lot of research in that area, and the fears of Medicare and Medicaid. The discussions of having some kind of health insurance for the seniors had provoked so much consternation with the AMA [American Medical Association].

VH: I think I shared in that because I was worried that there would be too much government interference, but I don't think it was as bad as we thought it would be.

I do remember, one time, going to this meeting of this county group [the Consortium of County Medical Societies]. The Vietnam War time was on then, too. I had gone to the Democratic caucus and was a delegate to the region [district convention] as an opponent to the war. This physician got up at our meeting and said anybody that could be a Democrat (and a delegate) was a traitor to medicine, basically. So the feeling was so strong. I can see the doctor/patient relationship affected when I see all the rules and regulations, like I just mentioned that one where we didn't have freedom to write off bills for patients. Even now, when I get bills from Medicare, I can't understand them. So I can see that part of that concern was legitimate, but the other side of caring for people who needed it and being able to do that really counter balanced by far the negatives, I think.

DT: You mentioned, a little while ago, about the physician who, basically, had gotten you to go out to Red Lake Falls, the one who was doing the lobbying at the State Legislature. It is my sense from looking at some of the documents that I've seen that

when it came to rural practice, there was a lot of lobbying going on to ensure that rural communities were getting better medical care. What was your experience of that?

VH: Yes, I have some experience on that. First of all, this physician—his name was Doctor Les [Lester] Dale—I think was a master politician. I learned a lot from him, but I wish I had learned more.

[chuckles]

VH: When I got back to the University, I'm not sure I was that adept at it.

For instance, we'd have a lot of the key legislators come up to Red Lake Falls even, and we'd meet them. On the night of the elections, you know, picking state legislators and such, he would be on the phone arranging for who would be on various committees, talking to the key people in the State Legislature, and making sure he had people in there that were supportive. It was just *amazing*. I was sitting there, I remember, in the office listening to that—not that it was all that negative. You really saw the interplay between healthcare and legislation and saw, how, sometimes if you can get on the inside, what can be done at that level. Before lobbying would even start, you're setting a situation up.

Then in the 1960s concern was building and building in terms of need in the rural areas. That was getting more and more the attention of the legislators. Family medicine then was probably the key focus of their concern, that we've got to get general practitioners out there. I can remember, for instance, Representative [Richard] Fitzsimons coming over here to the University. He was head of House Appropriations, I think. He made the statement, it would be, probably, in 1970, that you either support family medicine or we're not going to give the University any money.

DT: Yes, I've seen that.

VH: Another representative—what was his name?—from Pipestone… Verne Long [vice chair of the House Appropriations Committee and chair of special Subcommittee on Medical Education] said, essentially, the same thing. There was a lot of pressure… I didn't have any special insight, but I observed this from hearing these people speak and talking to the doctor that I practiced with on how these things were going. I don't know if there's more specific here.

DT: One of the things I understand about the early… In 1964 when the Hill Foundation sponsored a study to study the healthcare needs in the State of Minnesota. This was amidst national concerns about there being a shortage of physicians and dentists and nurses, but then this attention that the state was placing on healthcare needs within Minnesota. It seems that the Department of Family Practice being established was a product of that general and national and state attention on the shortage of health manpower, which you've kind of alluded to just now.

VH: During the 1960s, I thought I would stay in Red Lake Falls all my life; although, I'm not sure that my wife thought that. It's much different for the spouse in those circumstances; although, I think she liked it there, but I don't know if she thought we'd stay there forever.

During that time though was this so-called ferment going on, both national and state. I'd go to our Academy for General Practice meetings and hear all the… There was a lot of stridency and a lot of dissatisfaction. There was a lot of effort to start another medical school.

DT: Right.

VH: We knew about the Hill Family Foundation study. We, also, had worked hard on the national level to become a specialty. That was full of all kinds of internal and external dissention. For years, maybe thirty years, we kept trying to get approval from the AMA and other organizations for this. At the same time, the general practitioners were divided. Some of them didn't think it was necessary, and you could see that status would be a problem if the graduates might have more status than those that didn't take the residencies. So a lot of that was going on during the 1960s; all of that was going on. I didn't have time to get involved because I was so busy taking care of patients, but I did follow it.

I think when we became a specialty in 1969, I felt like I'd really like to be involved in this. I didn't see how we could continue and get doctors out to rural areas if we weren't down at the Medical School level helping out, educating the students.

I could also see that this twenty-five bed hospital could not survive. With all the advances in medicine, like coronary care units and all these things and with the improvement in transportation, it seemed to me that we should have a more regional hospital. We could be out there, even living in the community, and we could take care of, especially, the children, obstetric patients, the elderly so they wouldn't have to travel too much, but when hospitalized, you'd put them where there were more specialists, where there were other doctors that could share, and where you could have enough revenue so that you could afford all the advances that were coming in with technology. All of those factors kind of came together with changing medicine and the ferment going on at the state level and at the national level.

Then, probably, the key thing for me was when my partner decided—he knew my interest; I didn't want to leave him—he had a good offer elsewhere and decided to go. We had been trying to get a third doctor for years and couldn't do that. I remember one month where I didn't get a one full night's sleep because I was called out for this or that. I could have gone other places, but it seemed to me I'd like to get back to the University, and I respect my wife for going along with this, because we couldn't sell the practice and we couldn't sell our home. We had to come back at a much lower salary and into an unknown field where nobody knew what's going to happen.

I guess I got off the track.

DT: No, no. That's great. I remember seeing information about the effort—I think even the public health centers may have funded some of this—to establish regional medical centers of the kind you are mentioning.

VH: Yes.

DT: That's interesting. That was something that the rural communities were probably behind, it sounds like?

VH: Well, I don't think so, too much. In our town… It was a horrible thing to leave, because now they were without a doctor. They were still thinking of the older type doctor that did everything, so to speak. I think the businesses had a really hard time, because it was a big factor that if you had a town with doctors and a hospital, that helped business a lot and people would move more likely to the town. The school teachers would come. There were all kinds of ramifications that came out of it that probably overshadowed the value of a regional center. But that's why I was thinking you could still live there and get some of those advantages and have a hospital elsewhere. That's what eventually happened to the town.

DT: It's interesting to think of a hospital as an economic pull to bring people in, to bring businesses in, to encourage people to live there because there is a hospital to go to should you need it. It's an interesting thing to think about that I probably haven't appreciated before now.

VH: There's another thing, too, like when I came back to be a resident here, I was apologetic in my mind, because here I was a rural GP and, yet, when I got up on the wards in medicine and peds, I became pretty proud of the care we had given in this little twenty-five bed hospital. I saw, even though the attending physician might be a world expert in some particular disease, that patient didn't come just that way. He had all kinds of other things. I wasn't apologetic after that. I could see that even though we lacked a lot of the technology, we gave pretty good care, and I could see that patients are yearning for that. So I can see what they're [rural residents] asking for. Probably there's something pretty basic in human nature here that we've got to figure out. We haven't yet, I don't think, quite figured out how to put the two together well [i.e. reductionist, specialist care and comprehensive, continuous primary care).

DT: The other thing that you have mentioned is attending meetings of the Minnesota Academy of General Practice. You indicated that they had put a lot of pressure on having a department of family practice.

VH: That's right.

DT: I was wondering if you could go into a little more detail about what you recollect from those meetings. Herb Huffington seemed to be particularly strident in his activism, shall we say.

VH: Yes. You know, people remember that differently. I know Herb Huffington was a great advocate. I remember going down to his home one time and talking to him about all of this. I've heard other people say he was very strident, and I suppose he was; I don't know. I always heard him more as… There were some others that were a lot more strident. I kind of looked upon him as more balanced. When he got to be one of the regents that was a key thing. I think he was capable of making good, logical arguments and defending positions well. There were some people in the Academy that were more shrill and, you know, could be very abrasive. It made it more difficult because you had that going on. On the other hand, they felt they had reasons for it. You're talking about human lives. I could sense that, too, when I came down here. I kept sometimes getting involved in a lot of the university politics and would think, gosh, this is so far removed from those patients up in this little town of Red Lake Falls that are sick as heck and nobody is taking care of them, and here we are into these other things. I think he must have had a great ability as a politician, so to speak. He certainly was imbued with the idea of family medicine being in this rural area and was certainly willing to give of himself for this cause. I never knew him well, but would see him at these meetings and hear him, and like I said, I went and had a nice conversation with him at his home, when I was here at the U, just trying to figure out what to do. I found him pretty well balanced in those things. But, like I say, there were some people that were in the leadership there that… I mean there would be hollering, and I never saw him lose control or anything like that. I can understand. I know I talked to Mead Cavert about this one time, and he felt he was pretty strident, like you say. Maybe that's the case; I just didn't see that side of him.

DT: Sure. It seems as though he was so strident, because in the archival documents, it's always Doctor Huffington who was pressuring the U and talking to the legislature saying, "We need family practice." Then when he was a regent… Actually, when I interviewed Bob Howard, he said that Herb Huffington had tried to oust him as dean.

VH: Oh, my gosh.

DT: So based on the archival material, it looked like he was pretty strident, but it may be though, in balancing your recollections of him, that he was a more moderate voice within the Academy.

VH: I didn't know that at all, or I've forgotten it if I knew it. Gosh. I think he would be capable of threatening those things. The Academy was talking that way. I never was comfortable with that kind of approach. I think, partly… He was president of the Academy and, then, he got on the regents, he would be the vocal spokesman for this. I'm sorry, in a way, to hear that.

DT: There are two things related to that. There's been a very great sense from people I've spoken to and just reading things from the 1960s that there were these tensions between academic physicians and private practitioners nationally, but it seems that those tensions were particularly pronounced here in the Twin Cities. I wonder if that's something that you got a sense of.

VH: I think so. I did learn later on that it was going on in many states. I almost feel like here it was much more acute or much more virulent or whatever the word would be. It almost gives me a headache thinking about it now. You'd get there and the tension was really great. It was involving the regents like Fred Hughes. I don't know if he was president of the regents then. There was another one I wrote down, [George] Rauenhorst. He was a regent. He came and spoke with us one time at the U. For me, I wasn't used to any of that level of concern and discourse at such a high level. The fact that you're bringing money into it in terms of appropriations and anger and all the other things, and the fear of losing care… I think it's hard to appreciate, unless you're out there in those rural areas, what's that's like. These efforts gave us, perhaps, the best opportunity in the United States, eventually, to develop something here, because of the eventual support of the U and the money that the legislature gave. I do think that maybe we were one of the, I don't say forefront… I don't know if that's the word, but it was probably as tense here as anywhere in the country.

DT: Do you have any sense of why here it would have been so much worse?

VH: I have a couple thoughts. I think that it might go back partly to the research interest here, which was so exciting. I don't think there was that same interest in those people out there in those rural areas, in preparing doctors for that. I think there was a legitimate concern yet that we were a rural state. Other places maybe were rural states, but they weren't as high in the research. So we have a legislature where there was a predominance of rural… The way it is now, it would be more in the cities, the population, but, basically, during those days, I think that there was more of a rural predominance. There are probably other reasons. I think there was a legitimate concern about the attitude of the University towards the rural doctors and preparing people for that and, at the same time, a state that really was pretty much influenced by rural legislators.

DT: That's one of the other things that kind of stuck me about the Academy of General Practice… Certainly the State Legislature had their own interests in building family practice and building rural health care, but it seemed the Academy of General Practice was so plugged in to what the State Legislature would support and that gave them some advantage in getting their agendas…

VH: I think so. Verne [Long] probably is a lot of that reason. As I was telling the story about Doctor Dale, I think, in a way, they were pretty sophisticated even though they were rural doctors, you know, in the political world. [chuckles] In retrospect, I think that, perhaps, was the case. They were really fueled by a passion. You don't see that now.

DT: I think it was Doctor Magraw—it could have been one of the others; I think it was Doctor Magraw—who said that he sat on a plane next to Herb Huffington; they shared a flight together. Herb Huffington had revealed that the brother of the chair of the State Appropriations Committee was a general practitioner, so that was very clear familial connection.

VH: Gosh. [whispered]

DT: That explains a lot of how Doctor Huffington was able to get done what he got done. It may not have been Doctor Magraw who told me that; it could have been one of the other people I interviewed.

VH: Well, you know, that reminds me… What we were told to do is to let the leadership know if we were caring for any legislator. So the Academy knew the personal physician for every legislator in the state. They would use that. I remember that now that you talk about it. To that degree, like his brother-in-law, they tapped any of those resources, I think. [Thus the Academy could contact many legislators through their personal physicians within 24-48 hours] I guess Herb must be given a lot of credit for envisioning all of that.

DT: Another thing that you had alluded to was this move to establish a second medical school in the Twin Cities. I've seen a lot of information about that. Do you have anything more to share on that?

VH: Davitt Felder was the leader on that. I think the files are in the Minnesota Historical Society.

DT: Yes.

VH: I wish I had some of that myself. I remember he would come over to the U, sometimes, when some of Ben Fuller's… We'd have conferences. Davitt would come over to them, so there was an exchange back and forth. I think that was a very serious attempt that caused a reaction here at the University. He had the idea of lining up, I think, four or five states: South Dakota, North Dakota, and maybe Montana and maybe even into Wisconsin. He hired somebody that was really, I thought, very impressive to come up with a curriculum. The curriculum they came up with—I'd like to look at that again—I thought was just outstanding what they had put together in terms of how they wanted to teach this to the students. They wanted to emphasize rural preparation and tapping into resources that were available, like in the hospitals in the Twin Cities, and the two-year medical schools in South Dakota and North Dakota. They got money; they got, I think, $200,000 from the State Legislature in the late 1960s or early 1970s for planning, so they were in with the legislature. I was split in my thinking, because I really liked the concepts that they had put together and thought maybe it would work. I thought they would, perhaps, do a good job of training doctors. At the same time, you know, whether it would be a good idea to split the two institutions and have two medical schools, I don't

know how that would have worked out. I do think there were some good ideas there that they had. I know it seemed to scare the people here a lot.

DT: I was lucky enough to interview Doctor Felder I think in December.

VH: Ohhh.

DT: Yes, he had great information. I haven't had a chance to look at the Historical Society documents yet. Doctor Felder recently sent me some material.

VH: So he's still got the spirit of it?

DT: Yes.

VH: It was quite an innovation and, in those days, a very big innovation. Something like that has been copied at the University of Washington. They called it WAMI where they have a tie in to the adjacent states. Montana is one of them and Alaska is another one [and Idaho], and they've been able to make this network which is very similar, and I think it's working very well. So it could have been quite an interesting approach.

DT: That's the other striking thing about Minnesota and maybe what makes the tensions even stronger. People weren't just talking about Minnesota. They were talking about the Upper Midwest and being a resource base for healthcare providers in the Dakotas, and in Montana as well, being this was the only place with a medical school or a four-year medical school at least.

VH: Yes. They were *very* responsive to the needs of these states. I think they were not stressing so much the research and would have had a lot of emphasis on the teaching and the training and that kind of thing. It might have been nice if there could have been a balance. Now that we're thinking about it, in my own mind, maybe there would have been a synergistic opportunity here for both institutions, but there was some really hard politics going on.

DT: [chuckles] Let's talk about the Department of Family Practice. This very clearly ties in here. Doctor Felder had indicated that Ben Fuller was closely involved with the effort to get the second medical school, but, at the same time, he was the first chair of the Department of Family Practice. So, perhaps, you could elaborate on how you came to be one those residents and, then, your early experiences in the program.

[break in the interview]

DT: We're back again. You said you wanted to add something about medical school.

VH: One very exciting experience in medical school was going to the joint conference between surgery and Doctor Maurice Visscher's Physiology Department. That would be one of the highlights, because we saw how important the interface of disciplines is. They

were able to integrate those two disciplines. I think that was one of the greatest factors in terms of making it possible for all the subsequent cardiovascular surgery. I got the idea from that of the importance of being able to cross these disciplines and, especially, if there are boundaries, that there was a lot of knowledge to be gained and a lot of advancement in research. I really was fascinated by those conferences.

DT: It brings up another question I've had about Medical School in this time: the relationship between the basic sciences and the clinical sciences. It seems that Maurice Visscher offered a great bridge.

VH: Oh, yes. I agree.

DT: We were going to start talking about the Department of Family Practice. Could you explain a little about how you came to come back?

VH: When we decided that we would be leaving Red Lake Falls, we were looking at various options. Of course, the need was so great. There were a lot of opportunities, but I felt I would like to get involved in some sort of teaching as well as patient care. There was a place out in New York that I was very interested in at Montefiore [Medical Center Bronx] and Albert Einstein [College of Medicine].

But Doctor [John "Jack"] Verby was an extremely strong advocate. [chuckles] By that time, he was on the faculty here. I think he had a lot to do with me coming down here. I really liked Ben Fuller as well. I liked his scholarly approach to family medicine. In a way, he felt they may be even creating a new type of physician… I liked him when I was an intern. Then I really liked the idea of being where you could influence students and show them how fun it is in rural practice, but how important it is to be well prepared. I felt like maybe I could participate in that and be part of this movement.

Then when that so-called scholarship became available, Jack was in charge of recruit…

[break in the interview]

VH: …before this. I can still remember the day before I was to tell the people out in New York whether I'd be coming or not… On Sunday night, Jack called me. I was thinking at that time to go out to New York, but then that phone call did it, and we decided to come down here. It was just, again, a very exciting time coming here, partly because there were so many forces going on, like we have already discussed. It was a very tense time with the Academy and the University, all these things going on. At the same time, here we were embarking on an experience we didn't know how it was going to turn out. Would students buy into this? Would we be able to figure out a curriculum that was meaningful? Would it be accepted in the University setting? There were so many unknowns. But every day was quite stimulating.

What I remember, too, would be trying to figure out how we would do some of these interdisciplinary efforts. First of all—I think Ben would agree—we wanted to be sure the

doctor was well trained in traditional patient care, that he/she was able to do a good job there. But, at the same time, how could we prepare this person for all the things coming in the future? There was even talk about a computerized record, and one of the doctors was in charge of that, John O'Leary. How can we integrate the lessons from Behavior Science as we're caring for patients? So here we had connections with psychiatrists and sociologists. How do we improve our clinical decision making? That was really stimulating.

Ben brought in Vern [Vernon] Weckwerth to help us. In fact, he kind of ruined my life, in a way. I took a couple courses in statistics from him during that time. We would analyze articles, say, in *The New England Journal of Medicine*, in that especially. And, my gosh, when you got done with trying to determine are the conclusions consistent with the data presented, very seldom was that the case.

DT: [chuckles]

VH: He really taught us to be very critical in looking at medical literature. I think that was a great lesson.

So, here we are, trying to bring in other disciplines. I was hoping we could do like Doctor Wangensteen had done in surgery and bring in these others in a clinically relevant manner that we could advance our knowledge. Those were very exciting times.

There was a lot of tension both nationally and, of course, locally, as we've already talked about. What about accrediting these residencies? A lot of it [the controversy] hinged, in those days, on how much surgery and how much obstetrics should people have? There were lots of arguments about that. At the time we started, there were three different options for residencies, and I think only one of them included obstetrics. We, at the time, as far as I can tell, weren't planning to do obstetrics here.

[pause]

Again, from my viewpoint, it was kind of a cultural shock in terms of how do we convey these things, like the psychosocial influences on disease and community involvement, some of these things I've already talked about? How do we put that together into a way to be taught in preparing the students for what's going to happen in the future, and how do you do the interdisciplinary thing and all of those things? Where we had a lot of disagreement, I think… Those of us who had been out in practice, I'm not sure we made the best adjustment to the academic world. [chuckles] You have that traditional town and gown problem anyway. I think the hardest thing for me was the OB and also minor surgery. There are a lot of things out there you can do. In those days, we would still scrub in on surgical cases with our patients. I thought that you could learn a lot that way and, maybe from the days with Alan Thal…

[laughter]

VH: Because with some surgeons, you can just see how they handle the tissues with gentleness and grace and others don't. I felt that I could then direct my patients to the best care that way. On the other hand, I suppose it was redundant. I don't think we gave that much help scrubbing in on surgical cases. But, we'd be talking about the cases [as well, which was an excellent learning experience].

The obstetrics was the toughest problem for me, because I didn't see obstetricians going out to the rural areas, and I still don't see that. That seemed to be ignored. As far as surgery, I never had aspirations that we should do a lot of big time surgery, which some of the people thought should be done. On the other hand, I thought we should be able to handle a lot of the so called minor surgery. That became a real difficult issue. Also, emergencies and trauma… Again, you know, sometimes we'd have car accidents there. Sometimes, you'd have five or six people smashed up, and you're the only doctor there. Well, you've got to learn a lot about triaging and immediate treatment, stopping bleeding and all those kinds of things. As I've mentioned, deer hunting season…I hated deer hunting season. I'm not a deer hunter. They'd come in [with all kinds of gunshot wounds—arms, legs, chest, etc]. I never felt that down here [at the medical school] people appreciated that. I think leaving the town without a doctor, I felt very guilty. It was just a horrible feeling. I felt kind of pressured to do what I could to stick up for those needs and to be sure that doctors were prepared that way. I don't think I ever felt comfortable that this was appreciated.

Then, at the same time, you had all the pressure from the Academy, which we've talked about, going on. On one level, it was just a wonderful experience. I still look upon it as a wonderful experience. But, on another level, it was very tense and it was so hard to get this approach across in this [medical school] environment.

DT: I really got the sense from reading the materials that I've seen that Ben Fuller, in particular, was really trying to create this new role for physicians, that there was something different about family practitioners than what a general practitioner had been learning. It seems that you would have had so much difficulty demarcating the appropriate knowledge boundaries for family practitioners, because, as you say, the role of family practitioner is going encounter potentially everything you can imagine; whereas a family practitioner in practice in a more urban environment is probably not going to need that kind of knowledge because they'll have, presumably, the specialists that they can refer to. Was that tension there?

VH: Oh, yes, I think so. I don't know why we didn't think of… Like when I went to Saint Paul-Ramsey as head of their Family Practice Program, we worked out with the head of orthopedics and the head of surgery an extra year or extra experience. In orthopedics, say, one person took an extra three months. For people going into these areas, they both agreed to create that kind of an experience and give them the basic things. Again, wanting to know how to do a tracheostomy… It's hard. We get boundaries in our minds and how hard it is to move beyond that. It's just an amazing phenomenon in human nature.

DT: Did you find any resistance from the surgeons there that you perceived? Needing skills to be able to do minor surgery and to do trauma, did you feel the surgeons pushing back and saying, "This is not appropriate?"

VH: No, we didn't get so much there once we gave up the idea of doing gallbladders and…

…and some of those things. I don't remember getting a lot of resistance, but where the resistance came was from internal medicine, and that's been up to now, because we're too close to each other.

DT: Yes.

VH: That's where it's been over and over on political issues, from my viewpoint. That was a surprise. I thought we would be really close to internal medicine, because we were close, that we'd share a lot—and we do in terms of general internal medicine. But clinically, it's been more difficult in that relationship. I wish, though, if we had thought of tracks… There was some talk about tracks and things like that, but I don't remember that we really pursued that. We could have gotten around a lot of our difficulties by saying, "Okay, we agree on this basic core," and then those going on to those remote areas, give them more training. Maybe somebody who wants to be in research, give that person more. That's why I wish I could do it over again now from my vantage point, because I think there are some of these things we could have resolved easier.

DT: Ironically, the Division of Family Practice was initially within the Department of Medicine.

VH: Yes.

DT: Ben Fuller was an internist.

VH: That's right.

DT: Were there specific faculty members that introduced this concern who were internists?

VH: Ohhh, I'm sorry. I should make it clear I didn't see that here.

DT: Okay.

VH: Dick [Richard] Ebert was a big supporter and he stuck his neck out, I think, for Family Medicine. It was more what I've seen, subsequently, in my experience and also on the national level, but, no, I did not. I want to make sure that I don't say that it was here.

DT: One of the things I noticed from the material I've seen from the Academy of General Practice and some of the things that Herb Huffington was writing once he was a regent was that the Academy was very unhappy about the fact that Ben Fuller, an internist, was head of the department. So it seems that there was this backlash from the other side, that general practitioners, family practitioners were frustrated.

VH: That's right, and I never agreed with that. I felt we needed people like Ben Fuller.

Eldon Berglund, a pediatrician, was head of Family Medicine at Hennepin County Medical Center. I owe so much to him, because he taught me a lot. That was my first faculty position, and he taught me a lot about teaching and medical politics and all those kinds of things. He was kind of a philosopher.

In the early years, we had pediatricians and internists as the heads of departments. But the Academy, I didn't agree with that. I think that was overly strident on the Academy's part; although, I don't know all the details on why they took those positions. From my viewpoint, I felt thankful that other disciplines would get involved with us and help support us in those years. I've seen that subsequently, sometimes, where people in the other specialties weren't supported at the national level by family medicine organizations or elected to positions of leadership. I think that was a big mistake. I would say, too, that another area where we displayed kind of an anti-intellectual approach. I think we could be criticized for that as well, and maybe not appreciating the importance of research and scholarly activities, intellectual rigor, and things like that. So you can see both sides here. But I would say, on the other side, I never felt like we were being heard on what are the needs for patients and patient care and the problems out there when you're facing these issues. I felt kind of abandoned by the University, so I see both sides here, I guess you could say.

The debate about a new type of physician, I had a hard time understanding that. That's what you see in the rhetoric. In a lot of family medicine rhetoric, you still see that a lot of times. For instance, a lot of the rhetoric when you see a new curriculum revision—about every five years they do that—they're always talk about training a new physician for the future. You could look at it that way or the way that I prefer to look at it is taking the *best* of the old time general practitioner, the best of that [that apply to current and future challenges] and figuring out how to teach that and put it into curricula.

As I was mentioning, I don't think we've still learned how to convey that doctor/patient relationship and the appreciation of the environment from which one is coming and their cultural heritage in the same way that I got by being immersed into it in Red Lake Falls. I think we've had refinements. I really appreciated all that I learned at the University of Minnesota. We came down and I took courses in sociology and death and dying and took medical decision making and took several others in behavioral science…oh, and group dynamics from Pearl Rosenberg. It was amazing. All of that was very important. Yet, I would say that this concern that I've been coming back to, I don't think was really appreciated, and maybe you can't appreciate it unless you're out there and see what it's like.

DT: Did Ben Fuller appreciate where you were coming from?

VH: I don't think so. We had quite a few discussions, and I think if I had felt he appreciated, that viewpoint, I would have stayed here. But I hadn't the feeling, and I think from his side, maybe he felt I just wasn't appreciating his. I don't know. I don't know for sure. I felt I wasn't getting through and maybe I wasn't articulate enough. I don't know. I still don't know for sure what it was.

DT: It's interesting that you bring up the idea…I mean, that it wasn't rhetoric. It's almost like there was an effort to rebrand the general practitioner…

VH: Yes.

DT: …and package it in a different way so to give more status to something that was already being done, because the general practitioner had kind of lost status alongside the other specialties. It just looks, at least from the historical perspective, that it was really geared to make general practice legitimate and put it on the same kind of path as the other specialties; but, as you say, it was, basically, about ideally taking the best from what was already being done out in practice.

VH: That's a way to look at it. Also, I think, too, that you can define it. Everybody wants to put boundaries on it and I think you can't. You can have these principles and concepts, like continuity, comprehensiveness, and maybe a few others that you could throw in there. So, I think you can define the approach and try to teach that. Second, I think you can look at the needs of the population you're serving and train people for that. I've had a chance to work at the World Health Organization, to work in Africa, to work in Korea and China, Russia, Jordan, Latin America, and a few other countries and look at how all of those countries are developing family medicine. I think the same principle applies. What you look at is what are the needs of the population? These are dynamic. They change over the years. But I think you can kind of put boundaries or encapsulate the discipline a little bit in that way, but one has to be careful because then you cut out something that might be needed for the population down the road, and you say, "That doesn't belong to us." You're almost falling into the reductionist trap of the specialists, which is what you're trying to avoid. Yet, it's hard, because we want that nice closure on our discipline. That debate goes on now, not just from others, the debates from other specialties, but within our own discipline. When I tried to explain it to these other countries and their cultures, it seems like they could grasp it, that you work on the two areas [i.e., the conceptual and the needs of the population being served]. That they could kind of understand.

But when you talk about a new physician, a new kind of physician, some of this rhetoric, I don't understand it. I don't see that going on. I don't see the outcome of that in this way. Others might argue and say, "Well, you do, because they're able to use computers now. They're able to look at populations." Okay. Well, how does that change when

they're taking care of their actual patients? I don't know. That's worth a lot of debate and discussion, I think.

I think Ben was trying real hard to get this to become a "real" discipline like the other ones that would have the respect and you bring in all these things, and everybody would see that they were respected because they are able to handle clinical decision-making and a lot of the other things better, say, than their counterparts in other specialties. I still think even there you can merge both approaches together, and we could have come up with some sort of amalgamation or synthesis that would have been satisfactory to both sides, but it seemed like we couldn't get there, at least when I was there.

DT: The other residents that were with you, had they also come out of rural practice?

VH: No. Let's see. One came out of Anoka. Three out of Saint Paul. That's four. So I was the only one.

DT: I guess then, even among your fellow residents, you were probably an outlier because you had a different perspective?

VH: That's right. I think so.

DT: It's interesting because just the other day when I was preparing for this interview, I was looking at some documents and some notes, and I found a letter that you had written—or it wasn't even a letter. It was comments on the Family Practice Program in April 1970. It was where you in a few pages, basically, expressed your discontent with the way the program was being run, because it wasn't meeting the needs of the rural family practitioner.

You had even gone so far to say, "Unless there are changes made, I am going to have to resign."

VH: That's circulating? I wonder where…

DT: I can print a copy for you before you leave today.

VH: I'd love to see that, yes, and see how consistent I am.

DT: I was like, oh! Right! Yes! You were quite outspoken.

VH: I was trying, I think. I was wrestling with it, yes.

DT: It was clear for me in reading that letter that you weren't making the same… This is a time that the Academy was still making criticism of the program, but you were doing something else, that you really were trying to ensure the better education of family practitioners as they go out and do what it is they needed to do.

VH: That's why, I think, I never was quite comfortable with the Academy or either side. They weren't appreciating one side that I thought was so important with Ben and the others and vice versa.

DT: In 1970, there was the establishment of the Rural Physician Associate Program.

VH: Yes.

DT: Did that come out of some of the things that you were talking about or did this come from something else?

VH: I'm not sure. Of course, I knew Jack Verby real well. I was trying to remember if… I think he got funding for this. Was it around 1970?

DT: Yes.

VH: He got a couple-year funding for this. Well, when that came, it was kind of a surprise to me, but maybe I just don't remember that. What we were working on was a little different. I wish it would have succeeded. It was kind of a forerunner, maybe, to the University Academic Health Center. Ben asked me to represent the Family Medicine Department on a committee that was supposed to look at rural health in the state. I wish I had those documents. We had on there Doctor [Lawrence] Weaver—was he head of Pharmacy?—and the head of dentistry. [Doctor Ervin M.] Schaffer?

DT: Yes, that sounds right.

VH: And then the head of Mortuary Science was Robert… I might think of his name [Robert C. Slater]. He was a very nice person. Then, we had the head of Nursing. I don't remember who that was. Then, somebody from Public Health, and it might have been John Finn. I just can't remember who it was. This was called the Rural Medical Care Project. At that time, Dean Howard had asked this committee to come up with a plan that would respond, I suppose, to the State Legislature and all the pressure going on there, and how could the University have an impact in an educational patient care partnership. When I think about that, letting me be the representative was quite an honor to do that. Of course, they needed somebody to do the work.

[chuckles]

VH: I got to be the co-director of this group or co-chair or whatever they called it. We met and met and met and came up with a plan. I wish I could find that. This plan was to develop interdisciplinary remote site educational experiences for these different disciplines that I just mentioned in, maybe, four or five centers around the state that would be the hub of the wheel, and, then, you'd go out from there into the more remote rural areas. So the students would take part of their training together in like, say, Alexandria. That was one of the cities, I think. I think maybe Windom was one. We were even thinking of remote education in those days and educational modules and all

those kinds of things…again, the interdisciplinary. But you would come back to your home base. It would not be like the Rural Physician Associate [Program] where you're out there for nine months in that rural area with, maybe, one doctor or two or whatever. We felt that you needed a larger aggregation of key facilities in order to give the base, but, then, you would go from there out into those other places. We worked on that and came up with our plan. About that time, Doctor Dean Howard left under a lot of pressure and we lost, I think, the advocate for this. At the same time we were doing that, Jack was doing his thing that I really didn't know much about. After I left there and I was over at Ramsey is when he got it going at the University. Ours kind of fell down. I remember that I came back from Saint Paul-Ramsey or at Hennepin or wherever I was at that time to give a final presentation to the Council of Deans and Directors. I just never heard again what happened. But we had worked hard on it, and I think we had some real innovative ideas. It might have worked.

If you ever come across that Rural Medical Care Project, I'd love to see it.

DT: It sounds familiar, so I will check back over my notes, and if I can find the location of it, I can certainly get you a copy made from the archives. It sounds very familiar, so I'll keep an eye out for it.

VH: It would have been one of those things that might have had a stronger educational component [than RPAP] while still answering the need of getting out to the rural areas. We had considered, you know, quite a few options and, after a lot of discussion, and brought that forward. Just think…to get the dentists out there and the pharmacists out there and learning together.

Kind of paradoxically, we're trying that right now in Africa. I'm director of a project [World Organization of Family Doctors (Wonca)] in Africa where we're trying to do something like that in rural Africa.

DT: That's great. It's not just to get physicians out there. You have to get the other professions out there to provide the necessary support.

VH: I think so, and I think the legislators would have loved it. It would have been a great educational… I often wish that that would have eventuated.

DT: My understanding is that the Duluth Medical School's—I know it's just a two-year program established in 1972—emphasis is on training, preparing rural physicians. Do you think that the creation of the Duluth Medical School may have also taken the wind out of the work that you had done for the rural medicine project?

VH: I think so; although, if this had pulled off, they [Duluth] might not have had as much wind themselves. Did you say 1972?

DT: Yes.

VH: There was so much frustration then with the U. I think Bob Howard's idea might have forestalled some other things. I think the Duluth program has done well, but this might have altered the equation a little bit in how it would have developed. I don't know.

DT: Do you remember much about why Bob Howard left?

VH: No. The rumors… I never was in on it, but one of the rumors was the practice plan for the different specialties and the objections by the department heads. I never had inside knowledge about it, but that was kind of a rumor, and the idea of how can you can have independent fiefdoms? Of course, department heads like their independence which is kind of nice if you're a department head. On the other hand the greater good and how you work together was kind of the idea that I had of that.

DT: That's a sentiment that I've heard from several people and from Doctor Howard himself. That was his sense of why he had to leave.

VH: If that had continued… I think he was very sensitized to the need out there in the rural areas. I never dealt with him really, but I always had that feeling, and I always had the feeling that if I needed to, I could communicate with him.

DT: Ben Fuller, eventually, stepped down as department head. Were you aware of why he made that decision and what pressure he was under?

VH: Yes, I think so. I don't know if I had something to do with it or not. In some ways, I think I did. A couple people of this class that I was in left. There was a lot of pressure from the Academy and others to leave, too—not from the Academy so much, but there was pressure. I feel like maybe I was regarded as kind of a moderate in all this stuff. I'm not sure. When I finally decided to leave, I think that had an impact on some of the people pushing hard to get rid of Ben. Then, with the pressures of Bob Howard leaving and with the Academic Medical Health Center coming on board and Lyle French, who was more attuned to a lot of the politics… He was very attuned to the Academy of Family Physicians like the president, Dr. Chester Anderson. I can't remember whether Dr. Anderson was president then. He was talking to him all the time. I think all of those things built up, and it could be that, at least. Sometimes, I feel if I had stayed and tried to work out these differences, maybe Ben wouldn't have left. I mean maybe the pressures wouldn't have been so great on Ben. It's a delicate balance and, maybe, this had something to do with it. I know that Herb Huffington…that my departure seemed to influence him, I think.

DT: Certainly, it seems that he was pretty focused on getting Fuller replaced.

VH: Yes, yes. I think so, and I think he might have used that as one of his… I think it would have been harder if I had stayed there and really spoke up for Ben. That's why I think I worked so hard in my mind trying to get this across to Ben that we had to figure out a way to do this, because the rural doctors aren't going to support this if we don't. They're not going to understand this new physician that's being created when the need is

out there to help those patients. I feel a little guilty in a way, but, then, I don't know… I wish I had been able to transcend this some way or another, but I wasn't able to.

DT: It certainly seems that all the focus was stacked against Fuller. Huffington was a regent at that point and he had a lot of sway, obviously on medical matters among the regents, and then you had the state legislators from rural areas being powerful and kind of pushing for their agendas to help meet the needs of their constituents. It seems like Fuller was going to be a tough sell as…

VH: Oh! he was under all kinds of pressures. I agree with that. I was sensitive to that even when I came down there. In my mind, I wanted to support him, and I felt he didn't give me the chance to do it. They kind of looked at me as an insider, in a way. I think Ben and… Ed [Edward] DeFoe, at one time, thought I was like a spy. I don't think Ben ever said that, but I think Ed did. I never thought of it that way, because I was trying a little bit to be… Well… The pressures were tremendous against him. Like you say, the odds were stacked against him. On the other hand, there was that other part: that he was pretty stubborn.

He could be very stubborn. It's kind of like a Greek tragedy where you've got the strengths that become your weaknesses.

DT: You had left by the time that Ed [Edward] Ciriacy came down. Did you have any interactions with Ciriacy? It's my sense is that he was, basically, handpicked by the Academy to take this ball.

VH: Yes. [sigh] I knew him quite well, because we both came out of rural practice in northern Minnesota. He was up on the other side in the east and I was in the west. He was president during one of the critical times. I can't remember what year he was president of the Academy, in 1969 or something. Because of that, he was on the search committee [for the new chair of the Department of Family Practice and Community Health] and all those kinds of things, a very hard worker. [pause] I remember one time getting a call from him at two in the morning or one in the morning about some doggone thing. [chuckles] I was down at the U at that time. I have no idea now what it was. I didn't even get upset because I realized this guy was in practice and he was working till one or two. He wakes me up and never apologizes.

[laughter]

VH: We just talked about it. Whatever it was, I can't remember. That gives an idea of the intensity, again, that was going on.

After Ben left, my understanding even then is if he hadn't written a letter of resignation that I think Lyle acknowledged, maybe he could have hung on longer. But he had this letter and that was, I think, to Ben's credit, his ethical feeling that he needed the support there.

Then there became a search committee for the new head [NB. my notes indicate that this search committee was chosen by President Moos with advice from Herb Huffington]. I was invited to address that search committee. I'd like to find that address, too. After that, he [Doctor Ciriacy] stepped down from the search committee and became a candidate. Of course, the Academy was all for this. He was chosen. I think I supported that. I had nothing to do with Ben leaving, objectively, except what I've already mentioned. We [Doctor Ciriacy and Doctor Hunt] would get together when he came down here then. He was new, and he called me and asked me to come over as second in charge. He said that he only planned to stay a year or two, because he was a rural practitioner [not an academician] and he wanted to get this thing straightened out, but then he was going to leave. He said he would like me to be the head then. I didn't go over there.

There was something there that was very concerning to me. But we would get together. I'm just saying that in terms of our friendship. I felt we had a pretty close friendship. We would get together for dinner in the evening periodically and talk. It was a very hard thing to see what happened. Then the split became greater and greater. I don't know if you know all of that. It's a much longer story, the grievance that we had…Ed Ciriacy and me?

DT: No. If you would, elaborate on that.

VH: [pause] As I say, first of all, we were pretty friendly, because we had so many shared concerns and adventures, from my viewpoint, so much. I think he kind of respected the fact that I was going to go take this residency at St. Paul Ramsey Hospital. As time went on, and I was over at Ramsey, we were presenting for money from the legislature for the family medicine at Ramsey. People at Hennepin were, too, and the U. I think, perhaps, we benefitted from the concern about the importance of educating rural physicians. Well, each local group, including the Ramsey County people, boy, they're in there fighting for theirs. I remember one time, when I got the position to be head of the Family Medicine Program at Ramsey—that's another story, too, in terms of just trying to forge a path among the traditional and academic world—Eldon Berglund was sick, and he asked me to present for Hennepin County, even though I was in Ramsey [County], so I went and talked to the legislators and Senate Finance and House Appropriations [Committees] supporting Hennepin County.

[laughter]

VH: Then, a couple weeks later, I was there talking [for Ramsey]. They were shaking their heads. Who does this guy represent? At the same time, the people, Lyle French and the others, were supporting their requests for appropriations. So that was tension, I think, in terms of how big is this pie and how much of a piece to go to where? So we were almost caught in that regardless of personalities. There were some institutional issues there, like, should the funds be under the control of the University and then allocated from there to Hennepin County and Ramsey or direct appropriations? We favored a

direct appropriation. [chuckles] Of courses, Ed and the others would have liked the other.

DT: Yes.

VH: So there was something there [i.e., competition for state legislature funding].

But more than that, as time went on, I got elected to Grievance Committees. So these people [family medicine faculty], if they had a grievance, the theory was they could bring it up to the Grievance Committee and our job was to try to adjudicate some sort of resolution of it. Then, you could go up higher, up the faculty organization, to some level there. There was some the appeal goes up. I had felt that a lot of the people were being kind of abused, that they were being kind of torn apart if they differed with Ed on a variety of issues, and it seemed to me pretty vindictive. I think the fact that I was a little independent being over at Saint Paul-Ramsey, that's probably why I could take a stand.

Oh, they had a Promotion Committee, too. That was made up of associate and full professors. I was associate professor. Then, they elected me chair of that. Again, the same thing: I saw these people trying to get promoted. If they disagreed, they were just torn apart. It wasn't with just the academic issues that he tore these people apart… but also as human beings.

That went on for quite a while. I would have to look up a lot of this, and I do have some of these documents. So went over and talked to Ed about it. Again, this is like a Greek tragedy in Family Medicine. We have all these ideals that we're working on, and one of them is treating people with respect, your patients and others. And, here, we had a situation where it seemed to me within our own discipline, we weren't displaying the characteristics that we preached. I didn't get anywhere in our discussion. In fact, I practically got kicked out of his office. One thing that came back, later on, was the statement I made that I thought that if we didn't get this straightened out, there would be a lot of serious repercussions in the future for the department. I don't know if that was true or not, but Ed took that as a real threat that I would be working against him. From then on, it was very difficult. This was over an eight year period, something like that, or five year period.

This Promotion Committee…I don't know, there were maybe fifteen people in it, sixteen. They voted almost like fourteen to two [correctly, the vote was 9 to 2] to ask for a different chair of this Promotion Committee, not the department head, because they felt the applicants weren't getting a fair hearing. They elected me as chair. Oh, jeepers.

That didn't work out well at all. It was just a constant… He wouldn't agree to that. I think, legally, this committee…we were in the right [regarding the request for a new promotion committee chair].

Then, a couple friends of mine got really torn apart: Harley Racer and Dave Spencer… Harley was the worst, the one that just got to me so much. I can remember him coming

over. He had a petition asking Ed to resign. I can remember him coming over to my office at Ramsey asking me to sign it. Ohh… I think I must have taken a little while because. I think I came home and talked it over with my wife. I knew it was the end of… Of all the associate and full professors, almost every one signed this, except, you know, three or four, which should be a wake up call. From then on, I think almost every one of those that signed it, Ed got rid of one way or another.

So we had a grievance and that grievance went on maybe eight years. This is where I'd really want to get documents. I hope I'm accurate, because I'm giving you my viewpoint.

DT: I think I can verify it with the documents.

VH: We needed a hearing. When you do that with a formal grievance, it goes from the department then up higher. We couldn't…and I still don't know why. I would go talk to Lyle French, talk to Neal Gault. We would have meetings. We had four or five grievances that we felt were clear violations of University protocol and procedures. Finally, there were a couple faculty people that supported this: Professor Richard Purple [Laboratory of Neurophysiology, Department of Physiology], and then a sociologist [Professor George Donohue]. I can get their names. Anyway, they became our advisors through Jack Verby. Jack, of course, was pretty vocal. They advised us, and, then, there was a guy [John Kim] Munholland, or something.

DT: Mulhausen?

VH: No. This was different from Mulhausen. He was a history professor whose main area of expertise was studying the Holocaust in Nazi Germany. He was chairman of this Faculty Senate Committee, or something like that. He made the ruling that we should be heard at that higher level. I don't know we must have bounced over the Medical School. I don't remember how that happened.

Then there was a big hearing that lasted about five days and we had court reporters and [unclear]. We presented our case to a group of three people. I think that we were vindicated in, like, eighty-five percent of our points, but it didn't make any difference.

There was something going on there that I never knew and how this was being protected and why we weren't… The rules say you're supposed to have a hearing within six months or something, and it took us about eight years [from the time of the first formal concerns]. It was just a miserable, miserable time. It affected our family and everything as Mary Kay, my wife, just mentioned as I left [for this meeting with you].

I had some material on it but I didn't get to it. I didn't know we would go into it in this discussion. Also, I had other things I was looking at. This was a very, very sad situation. Thinking of all the idealism that we'd had that I've described and all the tension and trauma and, then, for us not to get, it seems to me, the kind of department and the kind of impact that we might have on knowledge and new knowledge and really making, maybe,

a quantum step in the idea of training generalist physicians. We had so much money from the legislature, and we had the support now of the Medical School, even though it took external pressure, but we did have that in Dick Ebert and others that were supporting this, and here we are among ourselves fighting and losing the battle that way. It's kind of a sad story, in a way.

DT: When you finally had this hearing, it must have been the late 1970s at that point, if it was eight years?

VH: It was in the 1980s.

DT: Oh! it was in the 1980s? Wow!

VH: It was probably around 1983, 1984 [September 1982 – Report of Senate Judicial Committee, January 13, 1983]. Yes, it had started in the 1970s.

DT: That's interesting, because given that Ciriacy came from rural practice and, presumably, shared a lot of your idealism or your agenda for training family practitioners. Because of his personality, I'm assuming, he didn't institute these changes in a way that would have led to the production of better trained family practitioners. I mean, he didn't meet the program's goals, would you say?

VH: Well, others would say that he did, I guess. We didn't have the continuity with some of the idealism that was under Ben Fuller and some of the conceptual basis of those interdisciplinary things and exploring new knowledge. He had more of a practical approach, perhaps, and turned out numbers, got these six different community hospitals going, so some people would say that those objectives were fulfilled, and in some ways that's true. Some wonderful doctors have been turned out. But that extra element that you might expect from an academic institution I don't think was there.

There were eleven or twelve external examinations of the department during that time, so we'd get upset and go to the dean or something, and, then, they'd have an external examination.

DT: [chuckles]

VH: Then, they'd have another one. One time, I analyzed ten of them, and they all pointed to the same problem, but nothing was done.

DT: So you do you think Ciriacy was being protected by higher administrators?

VH: Yes, I think so, and I don't know the reason.

DT: Do you think one possibility may have been because he was coming with so much support from the Academy of General Practice and the State Legislature, that that continued to protect him?

VH: He used that a lot, and he would threaten some of the people. At least he would tell me that, and I think that's true. I think he used it. Whether it was there or not, I don't know, if it had come to a head. But I think that was a big factor, yes.

DT: It seems that the State Legislature continued to be really committed to building rural health and primary care, so I guess his ideas would always have political capital as long as he was producing physicians to go out into rural practice.

VH: Yes, I think so. I'm not sure that was an accurate assessment, because, at the same time, the legislature was supporting Hennepin and Ramsey and Duluth, in spite of Ed being here and the University doing their thing. That belief was never tested, but I think that was the thinking, and I think he did use that threat a lot. I almost had a feeling there was more to it than that, but I don't know.

DT: Interesting.

VH: I have some nice letters. They're all good people. I had a nice letter from Neal Gault telling me he was hoping it would be worked out. He gave me some nice advice: "there's so much good in the worst of us and so much bad in the best of us that it's hard to know the difference."

DT: [chuckles]

VH: It's good to understand people that you don't… I think he was giving me good advice: don't be quite so idealistic about all of this. It's not just a good and evil going on. These are gray areas, and we're struggling with it and stuff like that. I think the same way with Lyle French…I think he grasped it. I think the Academy really liked him. He probably sensed what was best over all from that perspective, but, for me, I think… These were general practitioners, too, that were being hurt, and they had clout, too, with the Academy. If that had ever really gotten out to the Academy, I don't think Ed would have had the support as much, if they really understood what was going on. That's behind the scene. The big thing is it was kind of sad for all of us when I think about it. I wish we could have figured out a better way. I think when I got to Brown, I learned enough about the politics to kind of navigate through this better than when I was here. [This may be unduly apologetic considering the circumstances and power alignments. In retrospect, it seems as though we did remarkably well in maintaining our composure, integrity, and persistent focus over a decade of being blocked at almost every juncture.]

DT: One of the things, going back a little bit to when I believe you would have still been here in the program here, there were discussions about, alongside trying to define what the family practitioners would be and what they would do, who their patients would be. It seemed there was some kind of concerns about bringing enough the patients, and there was an effort to build a patient population through a comprehensive health insurance plan. Could you speak about that?

VH: Is this the one that Ben wanted to develop?

DT: I think so, the closed panel.

VH: Yes, the closed panel. That's right. Oh! they made a big deal of that. Yes, yes. I didn't have a strong feeling on that either, because I could see the advantage of this. They just went rabid on it. Ed Ciriacy was one of the big ones on that. All I can say is that was one that they really went after. Then, when Ed got here, he developed this plan that's turned into UCare now, so I don't know what how deeply he felt. It was used as a way to get at Ben, I think. Then, everybody was worried. There was this part of that concern about changes coming and managed care and all of those kinds of issues. Again, there's some legitimacy on each side, I think, but that clearly was used, which I thought was unfair, the way it was used on Ben.

DT: It seems that Academy and general practitioners were worried about their own patient populations. They saw that as competition.

VH: Yes, I think that's true, and using tax supported institutions to compete in an unfair manner. Again, with better communication, could that have been worked out? As it turned out, that's what's happened anyway. Of course, it hasn't been pleasant, in a way, the competition for patients. I think there could have been a way to resolve it. I think Ben was pretty firm on his viewpoint, too. Where could we have gotten this panel or maybe it could have been done without that. The medical society wasn't quite ready for that at the time, the medical community. A few years later, I don't think that would have been considered such a big battle.

DT: I guess with the federal legislation approving health maintenance organizations in 1974, the political landscape was quite different, as you indicate.

VH: That's exactly right. Yes, yes. So I think if Ben had come up with that a little later…

DT: He was a little too quick! His was the closed panel plan. Then, was it the Minnesota Family Health Plan that was eventually introduced? What was the name of Ed Ciriacy's plan?

VH: I don't remember at all.

DT: I can find that out.

VH: He was really concentrating on the poor, at the time, on indigent patients. So people weren't fighting over those so much.

I don't remember the name of that. [It eventually became UCare.]

DT: Competition over patients… That seems to be at the core of the town/gown tension anyway. At some level, it's about unfair competition, especially on the U side having tax-supported dollars.

VH: Yes.

DT: I guess my final couple of questions are less focused on family practice, but more about the reorganization. Did you get a sense while you were here, even as a medical student or, subsequently, when you were in the Department of Family Practice, about what the relations were like between the Medical School, Nursing, Dental, and Public Health School before and after the reorganization?

VH: Well… I'm not sure. But that was one reason I brought up this Rural Medical Care Project. There was always this sense that the other disciplines were kind of second-class citizens to medicine, to the Medical School, and they kind of controlled things. I know in this group that I mentioned, there were several deans involved, I never heard any dissention there at that level. In our discussions, I didn't hear backbiting among them. You kind of sensed that nurses didn't like the idea of being second class…if people did consider them as such. I don't think at my level I was aware of much of that; although, I don't know.

DT: Did you get a sense for the concepts and ideas behind the expansion and reorganization of the Health Sciences?

VH: A little. I think Rashi Fein was some kind of guru on this. Does that ring a bell?

DT: The name, yes.

VH: I remember a panel when they came. I just somehow remember him because he had a strange name, and, also, I remember reading some of his writings. The idea was they were going to come in and present how to go into the future with health care. I think I went to their panel discussion. My sense was that it was kind of already determined and they were brought in to come up with something that was going to be implemented. The idea, from what I heard, sounded positive, that you would have kind of an over all arching, hopefully, integrated group with equal status and things like that and that you could maybe speak with one voice like we tried to do with that rural health care proposal. That, to me, was kind of a forerunner of what could be accomplished if we all worked together and things like that. I would really love to read that report to see what they actually said. I think at my level, most of us felt that this was probably a good idea but it was kind of bringing in those converted already, and this was a way to legitimize what was being planned. That was kind of my thinking.

DT: I've heard that from others, too. I think even Bob Howard said that it was, essentially, just to give legitimacy to what was already going to happen.

VH: Yes. That's interesting. That was the vogue then around the country. In fact, I've read other articles to that effect.

DT: I should point out that you can actually get that report of the external committee on the structure and governance of the Health Sciences online through the University Archives. I should be able to send you a link to it. I think it's a pretty sizeable document. You can download it.

VH: One thing that was interesting to me is that, later on, there was an article in the *New England Journal* by Rashi Fein. I guess the reason I remember it is that—it was in their commentary section—he was talking about the commodification of medicine and that we were using terminology like industry uses and what that was doing to medical education and medical care, and the patient then becomes a commodity. Then you've got all those terms that you borrow from business

DT: Yes.

VH: I don't know how that relates, but maybe he's sensitive to those kinds of things besides just the external structure of how it would work most efficiently or whatever it was.

DT: Do you recall how the relations were with the Mayo Clinic during your time here?

VH: It was pretty peripheral. The dean [Doctor Raymond Pruitt] that started the medical school there, I heard him talk and discussed issues with him. I can't remember his name now. I was never asked to be involved in any of the decision making. I had correspondence with him off and on, too, come to think of it. There was a [Charles G.] Roland there that I had correspondence with, too, as they were developing it. Hmmm… [pause] I think he [Dr. Pruitt] would come and give talks occasionally to the Academy and other places, and I would listen to him and, then, sometimes, talk to him afterwards.

DT: I'm blanking on the name of the dean for the [Mayo] Medical School [Dean Raymond Pruitt].

VH: I used to keep all this material, and, then, when we moved back from Rhode Island, I threw so much away. I had a garage full of stuff [correspondence, presentations, deliberations by committees, articles, etc]. I wish I had those documents.

DT: Our archivist [Eric Moore] for the Academy Health Center, he would love it if he had all that material. So if there is any point with the material that you have, when you are looking for a home for it, I know the University Archives would be happy to have it.

VH: There is one nice thing from Dean Gault that maybe the archivist would like. I went for a year to Bahrain to work and help them develop family medicine. That was in

1980 and 1981. He wrote out on a piece of paper the key things, just five basic things, to develop in training.

DT: Oh.

VH: It was really good, and I would think maybe an archivist would like that.

DT: Yes.

VH: It's in his handwriting, and it's his thinking, and it was very well thought out.

DT: Probably what I'll do is I will either give you Eric Moore's contact information or I could pass on your information to him and he could contact you.

VH: I could contact him if you wanted to let me know…

DT: Yes. I will put this in an email to you.

VH: Okay. I had shown that to Mead Cavert, and he's the one that suggested maybe that would be something for the archives.

DT: Oh, absolutely. It certainly sounds like it.

Do you have any final or additional comments that you would like to share about your experiences here?

VH: Oh, I remember the name of one of these people. Chet [Chester] Anderson was the president of the Minnesota Academy, I think maybe right after Herb Huffington. He was, I think, a very good friend of Lyle French. I think they communicated a lot together.

I was hoping I'd click on the head of Mortuary Science, because I spent a lot of time with him, and I wish I could remember his name [Robert Slater].

DT: I'll probably be able to find out. By the time I give you the transcript, I'll probably know.

VH: Thinking about this Academic Health Center, there are two things that seem to me… One, it would be nice to go back and see what the objectives for this were. I think that the idea, at least that I understand, besides some of the political part, conceptually is a nice idea. However, to make it work, most of the time, as far as I know, they've had physicians that were in that position of vice president, so, in a way, I'm not sure how much different that had been. The second point: it does give you a chance of having a unifying philosophy and kind of an overarching conceptual basis for the health care disciplines that is a wonderful opportunity.

[extraneous conversation]

VH: I had written down [in notes to myself] that there's such a difficulty in balancing all these special interests, all the different disciplines, all the external pressures. It's just an unbelievable array of forces impinging on this center, so to speak, and whoever is directing it. So I think if the idea and the directors can hold on to an overarching framework that's kind of congruent with moral values and academic values such as the importance of scholarship, intellectual rigor, respect for the humanity of all people…they're all involved and maybe the most important thing is integrity, I think it's a chance to infuse those values throughout all the academic disciplines. At the same time, there's a chance for the academic disciplines to work together and reinforce this over all goal that's, hopefully, set by the person who is in the position of vice president. I see that's not easy. It's a very difficult challenge, but I think I have seen that done in certain circumstances by people in those kinds of positions where that flavor does spread throughout just by the way people are dealt with.

DT: Did you experience that at Brown?

VH: At Brown. I was thinking mostly of the president, [Howard Robert] Swearer, who was at Brown when I first came there. He came from Carleton [College, Northfield, Minnesota]. He was president at Carleton and became president there. I could see some differences with other presidents—although, they were very good. But there was some sort of integrity that came through that I think influenced the whole institution. When you'd go to the faculty meetings, he had patience. I don't know how he did it. Again, coming from a rural practice, you wonder why do they argue…

DT: [chuckles]

VH: …everyday about some of these arcane things? He dealt with it well, but you always felt that, even though there were political forces…I called them moral [values]—I don't know what the word is—would help give you balance. Maybe you'd go this way and that way, but, basically, these other values would come through, mostly related to the basics of education. Basically, that's why we're here and the scholarly work that comes with it and all the other things that I think are so tied in with the rigorous approach to your discipline that you're after and, ultimately, respect for the human being. That [overarching moral leadership] gives you a chance! You can do that with this kind of academic health center.

DT: It basically comes down to the individual who is leading in many ways to instill these values.

VH: It seems that way to me. I've never been there.

DT: [chuckles]

VH: It's easy to talk from a distance. Even the example I gave about the problems that were going on with Doctor Ciriacy, I think that, perhaps, at a certain level, none of that

would have been necessary, and you could still withstand some of the pressures from the legislators and the Academy of Family Physicians and others. But, you, also, at the same time have to be sensitive to why they were concerned and lead the whole institution in that direction. Like I say, that's very easy to…

It makes me very, in a way, sensitive to the problems of somebody like President [Barrack] Obama now. You're buffeted from so many different sides and can you hang on to a perspective that's congruent with your at least professed moral values? That's a challenge.

DT: Yes.

Well, thank you so much. This has been fantastic. This has been so illuminating.

VH: Really?

DT: Really, especially all the details about the family practice program that I didn't have access to and just learning about your experience in rural practice, too, is very revealing. I really appreciate your time.

VH: Okay.

DT: Thank you.

[End of the Interview]

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