

**Dr. John P. “Jack” Delaney**

Narrator

**Dominique Tobbell**

Interviewer

**ACADEMIC HEALTH CENTER  
ORAL HISTORY PROJECT**

**UNIVERSITY OF MINNESOTA**

## **ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT**

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

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

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

## **Biographical Sketch**

John P. “Jack” Delaney was born and raised in Saint Paul, Minnesota. He completed his bachelor’s degree at the University of Notre Dame in 1951. He earned a medical degree and doctorate in physiology and surgery from the University of Minnesota in 1955 and 1966, respectively. Between his degrees in Minnesota, he served in the U.S. Army at the U.S. Army Hospital in Fort Ord, California (from 1957-1959), completed his internship at Santa Clara Hospital in San Jose, California (1955-1956), and completed his residency in the Department of Surgery at the University of Minnesota (1959-1966). He has been a member of the faculty in the Department of Surgery at the University of Minnesota since 1965.

## **Interview Abstract**

Dr. John Delaney begins by describing his education at Notre Dame and the University of Minnesota. He discusses his perception Harold S. Diehl as Dean of the Medical School, C. Walton Lillehei’s surgical innovations, and Dr. Owen Wangensteen’s tenure as chief of surgery during Delaney’s time in the medical school. He also describes University Hospital administrator Ray Amberg and his assistant Gertrude Gilman. He discusses the changing fee system in hospitals in the mid 1960s. Delaney describes the cardiac program at the University of Minnesota in the 1950s and 1960s. He discusses his early research interest in bleeding from the stomach and his clinical specialization in gastrointestinal surgery. He describes changes in the Department of Surgery when John Najarian took over for Owen Wangensteen as chief. He recounts his experiences with Robert Howard as dean of the medical colleges, particularly his role in the faculty practice plan. He also discusses surgical nurses and the increasing emphasis on patient satisfaction with hospital care to receive full reimbursement for services. Delaney discusses the reorganization of the health sciences at the University of Minnesota, town/gown issues with Twin Cities practitioners, and competing medical school plans in Saint Paul and at Saint Thomas. He also discusses his later focus on surgical oncology and working with B.J. Kennedy and Seymour Levitt. Finally, he describes the ALG scandal.

**Interview with Doctor John P. “Jack” Delaney**  
**Interviewed by Dominique Tobbell, Oral Historian**  
**Interviewed for the Academic Health Center, University of Minnesota**  
**Oral History Project**  
**Interviewed at Doctor Delaney’s Office, Room 105, Dwan Building,**  
**University of Minnesota, Minneapolis, Minnesota**  
**Interviewed on March 27, 2012**

John Delaney - JD  
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I’m here with Doctor John Delaney. It is March 27, 2012, and we’re in Doctor Delaney’s office, Room 105 in the Dwan Building [Dwan Variety Club Cardiovascular Research Center].

Thank you for sitting down with me today.

JD: I’m happy to help you.

DT: Just to get things started, can you tell me where you were born and raised?

JD: I was born in Saint Paul, Minnesota. I’ve really never left the Twin Cities since, except for a stint in the Army and for an internship, which was at Santa Clara, California.

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

JD: I don’t know. I went to Notre Dame to college and I remember looking at the course offerings. I had thought about engineering or business or various other possibilities, but it seemed to me that the pre-med major had the courses that interested me the most. So I started off taking those and, pretty soon, I was swept up by the enthusiasm of my classmates about going to medical school. By the end of the year, I said, “Yes, I’m going to go to medical school,” but it wasn’t a real clean-cut decision.

DT: What led you to come to medical school in Minnesota?

JD: It was home. I lived at home during medical school. It was exceedingly inexpensive and it was a very well regarded medical school.

DT: Can you talk at all about what your experiences were like as a medical student?

JD: Well, it's a big topic. Certain differences, compared to the present, are extraordinarily interesting.

For one thing, the dean's office occupied two or three rooms. The dean [Harold S. Diehl], who was seldom in town, was a political figure. He was head of the American Cancer Institute and various other organizations. So the medical students rarely caught sight of him. He had a fierce woman at the front desk that they referred to as Dean Smith who terrified the medical students and really had a great deal of control over what went on. Then, he had a young internist who was his assistant and probably had a couple secretaries. That was the dean's office.

At present, the dean's office sprawls over multiple buildings with multiple presidents, vice presidents, and assistant vice presidents, co-directors, endless administrative people, which partly is the phenomenon of bureaucracy that tends to infiltrate and metastasize. On the other hand, there is a *much*, much greater need for administrators to accommodate to the other administrators in government and state and so on, all the rules that are dictating what you will do if you wish to continue your medical school or your surgery department or whatever it might be. For each of those, there are multiple people writing orders and that requires a cadre of people to satisfy those requirements and those directions.

DT: There wasn't that same kind of need in the 1950s then?

JD: Dean Diehl was a champion dean because he just stayed away and let the departments do as they saw fit. We had a series of very forceful and prominent departmental heads who, basically, ran their own small empires.

[break in the interview - equipment failure – a portion of the interview failed to record]

DT: You were describing [Doctor C. Walton] Lillehei's open-heart surgeries.

JD: Yes. We were talking about the many people waiting to come here for operations. That went on for quite a few years after that. That was about 1955. In the early 1960s, when I was a resident, there was still a long waiting list. The point of this has to do with the general tenor of the Medical School and of the Hospital Administration. It's a somewhat repressive of activity. For example, they could only do so many operations a week. The heart group would do quite a few, but they had enough patients waiting that they could have done three or four times that many. The Hospital said—and I just heard this second hand—“Well, we don't want to turn into a heart hospital. We have to have a balanced mix.” That spirit has gone on through the years; they want to stay balanced rather than expansive.

The consequence is that when the Mayo Clinic [Rochester, Minnesota] started doing open-heart surgery, they see things differently. They say, "We're going to expand. We're not going to shrink anything else, but we're going to expand." I don't know the details, but they built a new wing. If there was a shortage of operating rooms, there would be more operating rooms. If there was a shortage of intensive care beds, build a new intensive care unit. So they accommodated to the demands and, consequently, grew and have grown and grown and grown. Their policy always is to expand, not to try to attain what the administrators see as a balance. In part, I'm sure it's political, space limitations and fund limitations from the Legislature and various other things. Some of the other medical schools, I think, were more effective in expanding their capacity to accommodate those departments which had unique things to offer and, thereby, built up the whole school.

Another part of that phenomenon is once you get clinical action, it doesn't matter, it could be the Neurology Department, if there's a lot of ferment there, there's a lot of spinoff, because many of the patients there have other problems. They've something in addition to multiple sclerosis. They've got a thyroid nodule or a colon bleeding or something that requires attention. It stirs the pot, if there's a lot of activity. For example, heart surgery, I think, was a *tremendous* boon to the Cardiology Department, because the patients came pouring in.

At Mayo, the patients were pouring in and they had the world's biggest collection of heart specimens from Jesse [E.] Edwards from their autopsies. He had the world's greatest, in part, because they supported that sort of high volume activity.

As to the Hospital Administration, that has changed about the same way the dean's office has. Even as a resident in 1959-1960, the Hospital Administration was one guy, Ray Amberg. He had an assistant, Miss [Gertrude] Gilman, who was probably associate or assistant administrator. Then, they had a few secretaries. That was pretty much the Hospital Administration and the Hospital ran pretty well. Hospital Administration as part of the Public Health School. They'd generate a lot of administrators that were looking for things to do and a goodly number of them came here. They were good people, effective people. It grew. Now, of course, there are probably more administrators than there are doctors. It creates an imbalance. They've got to have something to do so they tell the doctors what to do. That's a cynical way of looking at it, but there is some truth in that. The administrators develop a life of their own. When the original need for an administrator disappears, the administrator doesn't. They devise something else to administer and it goes on and on and grows and grows and grows. It's very expensive. It's difficult to, as you probably know, keep excellent people on the faculty at the University because the monetary fruits of their clinical efforts, a good many of them, are, I would say, dissipating into Medical School administrative and/or Hospital administrative functions. It's a tug everywhere, but it's a fact of life.

Students, young kids or my grandchildren or even high school kids, ask me if I were going to do it again would I be a doctor. My answer is, "Yes, but I guarantee you it's

going to be a lot less fun than I had. You are going to be an employee under the direction of all kinds of people who want to guide you in what you're doing. Sometimes, the guide is pretty firm, that if you want to stay hired here, you're going to do what we tell you." That was not the case when I started. It gradually evolved as time went by and it's continuing to evolve now. I'm not opposed to federal control of medicine, but it makes being a doctor a *lot* less fun because there's an endless number of overseers and would-be overseers and committees that you have to satisfy in order to accomplish your work.

DT: I understand that it was a gradual change, but were there any kind of key turning points that you think increased this change, stimulated this change?

JD: Well, there was a *huge* turning point, which was, by no means, all bad and that was the onset of Medicare. That was right when I was about to be a chief resident in 1965. I was chief resident in 1966. Patients, prior to that, were taken care of with no physician fee. They were so-called county patients then. The counties were responsible for their care at the University. That did not include any fees for physicians, whatever the physician was doing. So, suddenly, there was medical income from those patients, who, if they were over sixty-five, previously, we took care of for free. Now, they were generating fees which was a *huge* boost to the economics of the faculty. The faculty really was living at a level that was probably lower middle class type incomes and, from then on, not just at the University, there was a straight, linear, rise year by year in physician income. The faculty shared in at least a part of that and, therefore, made it more tenable to stay on the faculty. But, then, as things progressed, it became less fun. It may have been more lucrative but a lot less fun being a faculty person.

It's a long answer to a brief question. Yes, I would be a doctor, but I would not anticipate the gratification that I experienced. I think that the people now don't worry about that, because they're brought up in another system. It seems to them normal. It seems to us pathological, for the ones who were there in the 1950s and 1960s. To the younger faculty, that's the way it is and they grew up in it. They spend a third of their time, at least, on record keeping. We didn't do that. We could spend it operating or seeing patients and so on. It's just part of the deal. It's essential, but it's not fun.

DT: You mentioned in talking about the expansion of cardiac surgery that the program at the University of Minnesota was limited in size by virtue of these various administrative and kind of financial pressures and not being able to expand in terms of space. Was that something that Lillehei and the other cardiac surgeons commented on or is that more your observation of things? Were they dissatisfied with how much they could grow?

JD: They weren't walking around talking about it all the time, but, yes, they would love to have done a much higher volume than what they were doing. It was not possible with the constraints. For example, intensive care was a bottleneck. Anesthesia was a bottleneck. There were multiple things that restrained their expansion. They did very well, but they could have evolved these things even more quickly if they'd had big enough groups of patients to be able to generalize about.

DT: There were so many exciting things going on in surgery in the 1950s and early 1960s. Did you get the sense that other departments within the Medical School felt that they were either part of that excitement or maybe left out of the excitement in some ways?

JD: Certainly Medicine and Pediatrics were both part of that excitement. They were *exceedingly* helpful in taking care of those people and, in turn, were seeing a volume and a variety of patients they otherwise would never have had access to. So they were tremendously helped.

Physiology was tremendously helped. I went myself to Physiology. It was a *wonderful* Physiology Department, but their orientation was to think about things and write equations on the blackboard, which is essential but insufficient. They did not have a good sense of what would be important in physiology that would be transferable to the clinical, particularly to surgery in those days. So many of the Surgery residents went to Physiology and the physiologists themselves admitted that was a great boon to them, because here were guys that were in a hurry and they wouldn't meditate too long. They'd do the experiment. Physiology was, "Let's think about this a little bit and talk it over." "Oh, no, we're only going to be here two years. We've got to get those experiments done." They would go along with that. They'd also go along with the clinical questions which the Surgery residents would carry with them.

For example, my interest was bleeding from the stomach. As a resident, I had seen a number of those. I thought, well, maybe the mystery had something to do with a special circulation in the stomach. There was a younger man there in Physiology, Gene [Eugene] Grimm, who later became the chairman and was my mentor. That was an interesting anecdote. I talked to Professor Grimm about my interest and he said, "Perfect. My major current study is blood flow in the gut and the stomach would be fine." He had some techniques that no one else had for making these measurements. So I fit very well into his plan so he agreed. He'd like me to work with him as a Physiology fellow. I told Doctor [Owen] Wangenstein that had he said, "I don't think that would be the best choice for you. He wanted me to work in one of the Surgery laboratories directed by a person who was not a friend of mine nor a friend of the residents and, in general, was a very difficult person. I said that I didn't think I'd thrive in that circumstance. So we left it at that. He, basically, said, "No" to Physiology.

The anecdote was this... I went to the Surgery office. There was a woman there who sat at the front desk, who was like a radio station. Whatever information came in would promptly be disseminated.

DT: [chuckles]

JD: And you knew it! I said, "Now, Marilyn, I want to ask you something. I don't want you to mention this to anyone. I'd like Norm Shumway's address." She said, "Why would you want that?" I said, "Well, you know, Marilyn... Just give me the address, please, and his telephone number." She said, "No, no. What are you driving at?" I said,



“Well, you know, it’s cold in Minnesota. The winters are tough. Norm’s got a lot of good things going on there [in California]. I’d like to talk to him about that possibility. But, Marilyn, I swear you to secrecy.” That was about noon. When I got home, my wife said there was a call from the Surgery office from one of Doctor Wangensteen’s lieutenants. He said, “Okay, it’s fine. You can go to Physiology if you want.” Now, he never would have done that had I confronted him, but using the side door... He did that exact same thing in certain difficult situations. Wangensteen would find an oblique way of coming at it where it wouldn’t be quite so confrontational.

DT: It’s interesting. One of the things I’ve learned about Doctor Wangensteen is that he and Maurice [B.] Visscher had a very good relationship. It’s surprising because my sense of things is that he would funnel people into Physiology. But for some reason, he didn’t always do that?

JD: I don’t know when it started. I think Walt Lillehei spent some time in Physiology. Ed [Edward] Humphrey who, subsequently, was the head of Surgery at the V.A. [Veteran’s Administration in Minneapolis], I think was the first surgeon to get the Ph.D. in Physiology. Then, subsequently, I did. Bob [Robert] Goode did, Demetre Nicoloff did among the surgeons. Then, many went over there and got master’s degrees. I don’t know exactly when the first Physiology alliance occurred, but I think it was in the late 1940s, early 1950s. Yes, that’s right. It was a regular avenue. I think both departments benefitted *greatly* from that alliance. Wangensteen did and Visscher did, too. They all thought that was a very fruitful arrangement of surgeons going back and forth to Physiology.

DT: Do you get a sense that was something that was quite distinctive about the Minnesota program, that Wangensteen was committed to training academic surgeons who had such good research experience?

JD: I gave a lecture on this subject last year. I was anointed the Surgical Alumnus of the Year with an obligation to give a lecture. The lecture was “The Role of the Laboratory in Surgical Education.” So I studied all that, and, indeed, Wangensteen was a pioneer, and I think the first, that said a condition of being a resident was to go into the lab. Other departments permitted residents to go into the lab and some may even have encouraged them, but Wangensteen said, “If you want to be a resident here, plan on being in the laboratory.” That, later on, became very commonplace, but I do believe he was the first one that demanded that that was part of surgical training. That policy slowly caught on elsewhere after a while.

The consequence was that at meetings, for example, there was a thing called the Surgical Forum. [This provided an avenue for young investigators to share.] At that time, it was a much smaller... In fact, Wangensteen invented the Surgical Forum, founded it in 1946 or 1947, something like that. In the 1950s and 1960s, the Surgical Forum would be constituted by about a hundred abstract presentations and, often, we’d have ten of them and more. That’s not true anymore. We still have a goodly number each time, but we aren’t dominant there as we were then.

So, yes, he was truly a pioneer in the idea that research is an integral part of surgical training. Still, even I don't think that's necessarily true if the person is definitely headed for clinical practice; although, I think it doesn't hurt people. It does help their thinking processes. It's a heavy price to pay if they know for sure at the end of this they are going to be in clinical practice. There was a big difference with different people. You couldn't predict it in advance. Were they going to be effective in the lab and probably more appropriately, were they going to enjoy it? Those who enjoyed it tended to really take to it. They'd work every bit as hard in the lab as they did when they were on clinical services. There were others who would simply put in their time. Then, there was another subset who were interested but, somehow, their minds didn't work that way and they weren't very effective. They weren't very productive. It was sort of a weeding process. A good many people who thought they would like to be academics changed their mind once they worked in the lab. Some were good in the lab, but they chose a practice as a more lucrative occupation. There are various things.

With passing time, there are fewer from our program as a percentage, fewer that take academics as a career. That was one of the subjects I went over. I went over, I think, the preceding six or seven years of *our* residents and what they did after they left their residency. I think there were 135 graduates and about 50 of them, at that point, which was a very short follow up, were occupied in academic positions of one sort or another. The history of that was a lot of people would do a few years of staff work, research, and, then, many would go to another institution. Many would say, "No, no." They'd go into practice, which wasn't a bad thing. They'd be outstanding practitioners. Everybody was theoretically trained to be an investigator. Of those, a rather smallish fraction, actually spent their life doing investigations. I don't know what that number is. If they spent ten years, was that important? If they spent three years...if they spent their whole life, is that what you needed? Very few people kept up their investigative work because they'd become chairman or something. Well, that would be a death knell for research because they had so many committees and budgets to work on. It's the exceptional chairman these days who can maintain himself in actual research. They can have helpers, PCs [program coordinators] that help them, but to really do it themselves is very difficult now.

DT: Clearly, you must have taken to the lab then?

JD: For unknown reasons, yes. I've been mystified by that, too. I obviously did like research because I'm still doing it. I may have set a record. I started in the Physiology Lab, which I was really running, doing the whole thing, in 1963, and I've been running a lab ever since, with interruption for the Army. That was about it. So I must like it, I guess. I'm not sure why.

DT: Did you go on to specialize within your clinical practice as well?

JD: We had the idea of the general surgery. I accepted that idea. But it was so general that the earlier faculty, like Rich [Richard] Lillehei, would do an open heart one day, a colectomy the next day, and maybe a thyroid the next day. He and [Richard] Varco were

truly general surgeons from the heart to the toe. About the time I started, that was gradually disappearing, probably for the good because then they started a heart surgery fellowship. Before that you just kind of rotated with Walt and that was it. With formal fellowships and, then, more and more fellowships, the logistics were such that, let's say, that if you got a plastic surgery service, well, you aren't going to do any more things that the plastic surgeons are occupied with. [The logistics of training changed.] Slowly general surgery became less general.

As time went by, I became less general. In the end, I did gastrointestinal surgery. In the latest years, I tended to focus more on endocrine surgery and on breasts. I did a lot of breast cancer. This wasn't all a rational steering of my course. It was just sort of the way things fell—and that was fine with me to narrow down my spectrum. The first operation I ever did when I left residency was an aortic aneurism. I did vascular surgery. I did lung surgery, esophageal surgery, parotid, and thyroid. I did all that stuff. But I could see though that there were guys down the hall who were doing more of it, so I'd say, "I'm not going to do any more vascular surgery." After three or four or five or six years, I'd say, "These guys do it every day. I'm not going to do vascular anymore." So it narrows with passing time.

That's a long answer to a short question. It's still called general surgery, but what you call general surgery is a lot more narrow than it used to be.

DT: Were you able to integrate what you were doing in the lab into the surgery that you were doing or were they quite separate demands?

JD: We hoped they would be integrated. There were some things we observed that at least were significant points in the clinical work, were scientifically interesting. But, it wasn't directly applicable.

We worked, initially, on gastric freezing, which turned out to be not a practical means to take care of ulcers. But, we learned a great deal about gastric physiology and about cold transfer and about mechanical injury or, in this case, thermal injury to the mucosa, and about what happens with cell populations in the stomach following the freezing. We studied that. For a long time, we were studying cell populations in the stomach as a consequence of other things, most specifically, when intestinal juice gets into the stomach, what happens? The stomach becomes inflamed. What happens to the lining of the stomach? We did years of experiments on that. It wasn't precisely surgical. We were discussing the subject of intestinal juice in the wrong place as a bad thing. What can you do about that? There were a lot of things done in that light. So it was somewhat related.

I did for a long time attempt to avert radiation injury to the intestine with things placed in the lumen. We had a lot of success with that, but it never transferred to the human, because we don't have access to the small intestine during the time of the radiation. We did have access to the rectum. You could put something in there when they're going to get pelvic radiation, but the materials that provided protection in the small intestine did

not work in the rectum. We wanted to think that a topical solution in the mouth maybe would diminish inflammation. People get terribly sore mouths when they get radiation to the head or the neck. So we were hopeful that might work there. We didn't get to the point where we could say, "Yes," or "No." Animal models were, for mouth radiation, weren't very feasible.

We worked on a whole variety of things. Most recently, the last ten years, I've been working on attempts to avert adhesions following abdominal operations. We have discovered a lot of things that might ultimately prove to be useful. But, thus far, we have not had anything we can apply to a patient. Thus far for me, it's been ten years. Thus for the research in the field, it's a hundred years and they still don't have anything that could be used routinely in patients that will diminish the phenomenon of adhesions following an abdominal operation. So I continue to work on that. So it is related to surgery, but it's not a new operation or a new way of looking at the intestines or things like that.

We worked for quite a little time on a directly applicable project and that was materials to help secure a repair of an abdominal wall hernia with various plastic meshes and then with various biologically derived pigskin applications that are now used. We did a *lot* of research on that and the vicissitudes and benefits of those different materials. That was a big thing for us in the earlier 2000s when we had three, four years of working with various prostheses for repairing abdominal hernias.

DT: Going back to the 1960s, Wangenstein retired in 1966, I think, and, then, Doctor John Najarian was hired in. What was that like for the department for Wangenstein to retire? How did that change things?

JD: It was *very* worrisome to the staff; I must say that. Minnesota surgery had an unusual system. But John, in retrospect, was exceedingly sensible. He didn't do anything to change one whit of the research lab. In fact, he started one himself, which became extremely active. He tells me—we discuss this off and on—that that was his major motive for coming here, because it was set up. You could walk in and be... You've got all these eager, smart, young guys that want work in the lab. Furthermore, the labs are ongoing. The resident doesn't go down and start some new process. That takes about a year to get going. The resident walks into an ongoing lab and, from the first day, he or she is doing productive work and, then, will gradually evolve into some original ideas where they're doing their experiments. It's *so* keenly set up both for the faculty's benefit and for the resident's benefit, but especially, it was unique for the faculty. You had this big labor force, and you had all the space in the labs, and there was a good deal of money available. For John, that was one of his criteria that made him decide to come here. He had a number of opportunities. He was *exceedingly* intelligent. He kept the conferences going the same way. He kept everything going the same, except that he enlisted what was then Saint Paul Ramsey Hospital and the V.A. Hospital into the clinical training for the very reason I was talking about. The volume of surgery at the University alone was insufficient for the number of residents. So our resident clinical experience was not up to par, well short of par. The introduction of making it all into one residency solved that problem, so the residents now have a very high volume and they did

progressively so after John readjusted that. That was a *huge* contribution to the clinical side. Otherwise, he was very enthused about the laboratory for the residents as part and parcel of training.

Furthermore, he was enthused about the degree program. The degree program was a thing that Wangenstein developed that he was much criticized for. A Ph.D. in surgery? A “give-me-a-break” type of thing. It was the real deal. Initially, you had to pass two language tests, have a basic science minor. You had to pass all the exams for, in my case, biochemistry and physiology. Then, you had to pass innumerable exams. Then, you had to write a thesis just as though you were any regular Ph.D. student. So it was the real thing. It may not have been quite as rigorous as your experience in...

DT: History and the sociology of science.

JD: Yes, yours was probably more rigorous.

It was a very good incentive for the residents to jump through all the hoops of getting a degree. They did a lot of things they otherwise would not have done, particularly writing a thesis, which, you, I’m sure, experienced was a *very* educational experience. Not everyone took degrees, but a good many of them did. That is drifting off with passing time. Maybe it’s appropriate, because, now, they’re, I think, sufficiently inspired to do things that don’t require the demands of a Ph.D. program to get them to do. I think it’s still a good thing, but I don’t think it’s that essential. It was very controversial. John, he did a couple years in research laboratories, but he did not do any degree work. He could see that the degree work proved to be very stimulating and very helpful to the residents in their research. You’d sit through all kinds of biochemistry and physiology lectures, which, without the prod of needing the credits and all that stuff, probably would have spent it in the lab operating on dogs or something. You could say, “I’m just so busy. I just can’t get over to that lecture.” But you had to have the credits in order to get the degree. To get the credits, you had to take the course, so I think it was a good symbiosis.

DT: How was Najarian’s appointment as chair received by the faculty in the department?

JD: With a lot of misgivings. It was very poorly received by Wangenstein because, having trained *all* these academic surgeons, he thought *surely* one of them would be selected. Such was not the case. So he was very disappointed. The rest of us were, I would say, more apprehensive than disappointed. We knew the weaknesses of many of the people that would have maybe been considered for the role, like Walt Lillehei, a brilliant guy and very energetic, but not an organizer. There were others of that ilk that were very good, but probably not appropriate for chairman of this particular department. So John had all the tickets and had a great reputation. So I think we saw him with an open mind and were won over in a fairly short order, because he said, yes, we were doing just fine. Keep doing it. That was, I think, a brilliant move on his part for him to observe what was happening. He said, “Let’s see how it goes.” He found out that it went very well, so he didn’t change. Virtually, he changed nothing about the research program. He did change quite a bit about the clinical program.

DT: You mentioned earlier about Bob Howard and how he had tried to change the faculty practice plan and he faced opposition from surgeons and others. Apart from that faculty practice issue, did you feel that Dean Howard's decisions in any way impacted what you were doing as a surgeon?

JD: I'm trying to think of his years as dean...

DT: Just in the 1960s.

JD: While I was on the faculty, he was gone. Well, you probably know better than I. I think he was done before about 1960. He had had maybe three or four years in the dean's office and, then, he was sent back.

DT: He started in 1959 and, then, he, eventually left in 1970, but the faculty practice issue...

JD: He wasn't a dean for eleven years.

DT: He was, yes.

JD: Nineteen fifty-nine through 1970?

DT: Yes.

JD: Is that right?

DT: Yes.

JD: Oh, boy, that shows what I know about history.

DT: [laughter]

JD: Don't believe a word I say.

I don't know. I didn't feel his input except on that particular issue, which represented, of course, money, but it also represented the idea that the dean has got to run this school, not the department heads. That was just one of the tools by which... If you control the purse strings, then you really run the whole institutionw.

DT: I actually interviewed Bob Howard a few years ago. He talked about the clinical practice, the clinical income as being something that really stymied his tenure. But, he, also, reflected that as dean, he felt like he had relatively little power. The biggest power he had was how much space he could assign.

JD: Yes, and appointments. The dean had an absolute veto on appointing a new chairman, which is significant power, but it's intermittent. I would agree with him entirely. He was stymied in his ambition to control things. Personally, I consider that a good thing. Obviously, if I were sitting in the dean's office, I wouldn't consider it a good thing.

DT: [chuckles]

Did you have much involvement with teaching medical students, not during your residency, I assume? But when you first joined the faculty, how much teaching were you expected to do?

JD: Well, I did quite a bit as a resident. Yes, they'd be on rounds with us all the time. It pretty much was the same in conferences; they'd be there and I might talk to one of them and ask them a question. I would have a sporadic lecture, but not like now. Now, it's very formalized. I'd have a lecture every so often on breast cancer or some subject...thyroid disease. But that was not a major activity. We'd have the students with us at all times in the operating room making rounds and somewhat in clinic, but that later became a problem, because the students became too busy in the operating room to be in the clinic to see what we did with the outpatient. There's some of that now, but not much. So in surgery, the student was primarily exposed to *inpatient* or maybe same-day surgery, but not surgical practice. That, I think, is the case in some of the other departments, as well. It is a difficulty that's not really solved: how to learn office practice while you're spending very little time in the office.

DT: Do you think the role of nursing changed or the role of surgical nurses changed during your career?

JD: Well, if you define surgical nurses as in the operating room, I think it became more stressful, maybe. They have a lot more responsibilities for record keeping, which is deadly. It really takes them away from their clinical focus. So in that sense, it changed. More and more things were imposed upon them that were not straight nursing. They were answering phones and keeping the records straight and things like that. So that to our disadvantage, I think. Now there are nurse practitioners that are serving as assistants in the operating room in lieu of where the residents are otherwise occupied. I'm told they've been extremely valuable.

Nurses on the surgical stations are under the same pressures, I think, and have been tremendously diverted. When I first started as a resident on the staff, you would not think of doing rounds without at least one of the nurses there and often a couple of them. Often the charge nurse was right there on rounds and would say, "Mrs. Brown, yes, yes, she vomited last night." Otherwise, as time went by, they were at the desk writing and they simply weren't available to go on rounds with us. The consequence was that if Mrs. Brown vomited last night, she'd better be alert and tell you that or you might find it in the notes. Then, concurrent with all that, everybody is recording everything. So what used to be a little thin sheet that told you Mrs. Brown vomited, you could see it all one page.

Now, you page through Mrs. Brown's uncles and aunts had diabetes, and her uncle was not satisfied with the reception in the emergency room, and on and on, *piles* of papers that obstruct trying to find the fact that you want to know what the hemoglobin was that morning. Well, now, that's a lot simpler, but, in the earlier days, that was something that was hidden somewhere. Initially, that was right there. You'd have one sheet of paper, one nurse, and rounds were tremendously efficient. They gradually deteriorated because of the nurses being diverted I'd like to think mainly against their will. They'd a lot rather be out taking care of patients than writing and writing endless notes which will never be read to satisfy the administrators who've got some defense if some kind of suit comes up. That was about it...their wasted time and space.

I proposed, not seriously, one time a Ph.D. or maybe at least a master's thesis for hospital administration student that they would take all the women that came for deliveries or say all the people that came for myocardial infarction, everybody that came in for gallbladder say, and look at the charts. Don't really look at them, just collect them from the year say 1965. Maybe you could do it progressively, 1960, 1970, 1980, and so on. Take all the gallbladder cases and weigh the charts and in 1970, weigh them again. I'll bet you you'd find a minimum tenfold increase from 1960 to 2000...minimum tenfold, all of which defeats the person also trying to look in the charts to garner records on some special illness, the outcomes and so on. You've got all that paper to run through. The digitized records are supposed to help. So far, the testimony is they take more time than handwriting them. They tempt more, in my view, committees and more administrators to say, "Now, we've got to record very carefully on every chart was it convenient when they were taken from the operating room to the recovery room? Were they well treated? You have to check that one off. Did you discuss the fact they moved with their relatives, which you ought to do anyway, but it's not that all of it has got to be recorded. I think it's a manpower diversion and it ups the expenses and diminishes the satisfaction of the caregivers who become record keepers instead of caregivers. I think it's a *terrible* trend. I don't worry about it very much because I know it's going to get worse, so why worry about it? It's just going to get worse and worse and worse. I don't guess it's unique to the U.S. or it's certainly not unique to the University Hospital. It's a social phenomenon.

But now there are piles of records; piles of money. You probably know that's going to be one of the elements of a hospital getting paid. The patient satisfaction is going to be an element of control. Do you get the full price or do we dock you? So there's a very strong urge to have patients satisfied and so testify upon their departure.

DT: I actually noticed that when I was looking at material related to University Hospitals in the 1970s. I saw that from the late 1970s through the 1980s, there was an increase in focus on patient satisfaction and patient satisfaction became such a priority through the 1970s onwards. So it's interesting that you reflect...

JD: But compared to the 1970s and 1980s, it was *nothing* compared to now. I think the reason being is there's money involved. If you lose money by having dissatisfied patients, then you're going to see to it that they're going to be satisfied. That's really what has driven it, a worthy goal.



DT: It's interesting that you say that the federal regulations changed what's required to get reimbursement. I guess what was interesting in the 1970s and 1980s is the increasing competition from other hospitals and HMOs [Home Maintenance Organizations]...

JD: Absolutely. In my opinion, most of the private hospitals were more effective than we were. We had a number of impediments. One of them is teaching. You going on rounds and you've got two students and an intern and you tell them, well, "Mrs. Jones, we thought we were going to partial hysterectomy. We had to do a total." Mrs. Jones is lying there hearing all this and not everyone was necessarily happy with that. Some of the patients loved it. They thought it was great that a lot of people were watching them. There's some truth in that, but some were disturbed.

Our administration was not oriented to efficient profit making. Now, that may be a venal motive, but with that comes the urge to compete. We've got better looking rugs. You don't have a dirty rug to walk over in order to get to your room. That kind of stuff was not a very high priority in those days. I don't think we competed—we still don't—on the attractiveness and the efficiencies in the outpatient departments. They're *much* improved, but I still think they're well behind, say, Abbott [Hospital] or some of the others, or certainly Mayo, which is very, very efficient.

DT: I'm curious, particularly during your training but then your time as faculty, whether the Mayo Clinic served as this competitive presence for surgeons to go into the program. Did you feel that you were competing for patients with Mayo?

JD: I think so, yes. There is a public perception. I'll go to Mayo and get the best, which had some validity. But, still, when you get there, you're going to get a certain surgeon. You aren't going to get Mayo Clinic. Somebody's going to be doing that operation. Even Mayo has some surgeons who weren't a lot better than others. Similarly here, we had some surgeons who were probably superior to the best guy at Mayo and, then, some who weren't all that great. To answer your question, yes, I think we were in competition and still are, particularly for the Twin Cities bunch who revere Mayo as the... If you're a Catholic and consider the Pope infallible, that's kind of like the Mayo Clinic for the Twin Cities. They do a good job; no question. But we see quite a few complications arrive from there and I'm sure they see some that come from us. The patient is smart enough not to go back to the guy that caused the trouble.

DT: [chuckles]

During the 1960s, a couple of things took place in the Medical School. Most significantly among all the health science schools was the reorganization of the College of Medical Sciences into the Academic Health Center. I wonder if, while that process was going on, you were aware of that going on and did it impact the Surgery Department at all?

JD: Well, yes, to the first. I was aware that something that was happening, but, as far as I could see, it had no impact on my activities. It probably had an impact on the dean's activities. Of course, they had to expand the administrative offices. Then, he had more people to answer to and, subsequently, the vice president then, not just the Medical School.

DT: It was in 1970 that the position of vice president for the health sciences was created and Lyle French was the first person appointed.

JD: Yes.

DT: Did you get a sense that there was support for Lyle French's appointment?

JD: Yes, I think so. I mean, if you're going to have a vice president, Lyle would be a good guy. He proved to be *extraordinarily* effective with the Legislature. I knew a few people from the Legislature and they just admired the hell out of Lyle French. He knew how to talk to them as one of the guys, you know. He had a skill like that that few people had. Some of his successors did not receive the same greeting at the Legislature. So he was very good.

That building down at the end, what is it they call it? They called it Building A.

DT: The Phillips-Wangensteen?

JD: No, the other one.

DT: Moos [Tower].

JD: Moos, yes. Moos the president [Malcolm Moos, President of the University of Minnesota]. He was a good guy, but he had *nothing* to do with that building. That building was a creation of Lyle French inveigling the politicians, to support that construction. By any standard, it should have been the French Building.

The Phillips-Wangensteen got its name because there had been a fund set aside by [Jay] Phillips at the urging of Wangensteen to build a new research center. Well, by the time they finally got it built, I think they managed about one floor with the Phillips' money. That's the eleventh floor of the Phillips-Wangensteen. Anyway, that was the genesis of that particular naming.

DT: With the reorganization of the health sciences in anticipation of the College of Medical Sciences, the School of Nursing and the School of Public Health were more autonomous than they had been under the College of Medical Sciences. Did you get a sense that there were any relationships with the School of Nursing, with Public Health, and with Pharmacy? For example, did they change at all as a result of this reorganization?

JD: Here's a very specific example... The answer is yes. The one we felt was the Nursing students no longer completed a full rotation in the operating room. The Nursing faculty considered that superfluous. They'd come for a few days of observation. There was a time I think they spent three months. I'm not sure, but they spent a substantial time. We'd see the student nurses in there all the time. They got a real feel for it. I don't know, but it might have recruited more to that career or it might have repelled some by all the tension in the operating room. I'm not sure. We liked to see the nursing students in there and that ceased to be much of a presence. That was directly a result of that reorganization, because the Nursing School began to deem itself much more academic. Others like Saint Mary's [Hospital] could teach the nurses to do clinical care and all that. I thought the nurses were certainly weak in operating room experience and I thought they were maybe weak in clinical experience.

DT: Did that have implications for the nurses that graduated and then worked in those settings?

JD: You know, initially, they fumbled around quite a bit, but I think they were just fine after a few months of experience. They worked into it. The ones in the earlier days had the few months of experience before they arrived. I don't know that it did any lasting harm, but, temporarily, you'd see a lack of students around where it used to be pleasant to have them and help teach them.

DT: I wonder, what were relationships like with the surgeons who were working in private practice that weren't involved with the Medical School?

JD: That has always been a sore point. Our alumni—in contrast with other medical schools—would go out and practice and that would be the end. They would not be supportive of the University surgical program. Now, that also evolved as a couple of the hospitals began to take residents. Then, they became extremely helpful and extremely collaborative. Certain individuals always, many of them, considered us competition and the enemy. Our own graduates would badmouth us. We never understood that. There are cities where there are certain schools where the practicing community is very supportive of the university faculty. We're getting a little touch of that in the Fairview [Hospital] system, more interaction with the private practice people. So I think it's improving. Through the end of the last century, we were deemed the competition and not to be helped. We'd get occasional referrals if it was some disaster, but if it was a regular case, they'd do it themselves. I probably would have done the same thing. They've been *hugely* helpful in resident training, the private practice people.

DT: Obviously, your experience is with the surgeons in private practice. I wonder if you have a sense of whether other departments in the Medical School had similarly tense relations with their alumni.

JD: I think it varied. I think some Medicine people were much more active, coming for conferences and some would have turns making rounds with the students and residents. I think that Medicine had more collaboration with the community. Orthopedics always

had quite a bit of collaboration with the community largely driven by the training. I don't know the answer for most of the departments. I don't have an easy answer to your question.

I always thought that Pediatrics was an *outstanding* academic department. An outstanding clinical department. But I think there were a good many students that chose to go into Pediatrics on the basis of their experience in the University Hospital. It was very exciting, pioneering bone marrow transplants and pediatric oncology, all kinds of exciting things. I think a good many of them—not just at the University of Minnesota—that went into pediatrics were disappointed about spending their whole day with kids with runny noses and vomiting and giving shots and well-child physicals for the schools. You know, their activities were a lot more preventive medicine and less acute illness. For some people, that's good. It's very good for the national economy, but it's not as interesting. When there's a bone marrow transplant over here and ten kids with stomach flu over there, it's another ballgame. I don't know how they do now, but I think the students lacked the experience to see what office pediatrics was like and an inordinate number then chose pediatrics on the basis of hospital pediatrics.

DT: In reference to the same point, were you aware of efforts in the 1960s by Saint Paul, not just Saint Paul, physicians, a group of physicians to establish a second medical school in Saint Paul?

JD: Oh, yes. Yes. We always thought it was sort of a joke. They didn't; they were very serious. Davitt Felder was spearheading that. He was a nice guy. He was trained at Harvard, I think, and came here. He joined the faculty briefly but he got in a fight with Varco and, from then on, he was a bitter enemy—he went to practice in Saint Paul—of the University. Part of the enmity came out with the idea that he was going to start a medical school, which was a *very* bad idea. It would have been disastrous.

Then, [University of] Saint Thomas decided they were going to start one here about ten years ago, an equally disastrous idea. They just didn't get it. They were inviting a mighty money siphon into their midst. They were going to collaborate with an insurance company, Group Health or something, and combine to start a medical school.

My brother is an attorney and he is a Saint Thomas graduate. They wanted him to go on the board at Saint Thomas. [Father] Dennis Dease was the president. Dennis Dease invited him to come on this board there. I don't know what the whole discourse was. Dennis said, "Do you see any problems with that?" He said, "I'll tell you one problem. Starting a law school is one of the dumbest things I ever heard of," and they were in the throes of thinking about starting a law school. That pretty well finished his prospects as a board member at Saint Thomas.

Stan [Stanley S.] Hubbard, who is a friend of mine, the guy that runs KSTP [ABC affiliate for the Twin Cities] also was, I think, helpful in scotching that foolish idea. It would have been a disaster for Saint Thomas. It would have been a second-rate medical school. Their idea was they were going to treat ethically and compassionately in family

practice. That was to be their goal. In essence, they would be second rate and probably fail in developing good family practitioners.

DT: One of the central issues, it seemed, for Davitt Felder and his colleagues who were pushing for the second medical school was a critique of the Minnesota Medical School, that it was primarily interested in graduating specialists and not in graduating generalists who would then go out into private practice and go outstate.

JD: Yes, I think it was a fair criticism, but the numbers weren't that bad. Then, when the Family Practice Department started, that one year, just about fifty percent of the graduating students went into family practice. That was *hugely* successful and it scotched that particular complaint. That would be a rationale or a rationalization for starting a new medical school. "We're going to teach people about ethics and compassion and psychology and all that and, besides, we're going to encourage them to be family practitioners" was, I think, their argument. It had some appeal, but I think it would not have been successful.

DT: It's interesting because their efforts failed, but, then, the University of Minnesota did set up the Duluth Medical School. It was just a two-year medical school, but it seemed that Duluth had kind of adopted some of the priorities.

JD: Yes, they did. I think it functioned much very well in Duluth. At least, in the outset, they were in the heartland of family practice doctors, smaller communities, and I think it was a very judicious thing to do. Are they a four-year now?

DT: No, it's still a two-year.

JD: The students that come from there—I used to see them—are very good. They got excellent training in Duluth and were ready to go. They were enthusiastic. Whatever they did to them at Duluth, I saw it as very good.

DT: I've had a couple of friends who applied there and some students who've applied there and, even now, they prioritize those students who want to work in rural underserved areas of the state in primary care.

JD: Yes, as does the Family Practice Department. I don't know how they interdigitate with Duluth, if they're competing or complimentary. There is an elective year of community family practice in their junior year.

DT: You mentioned about the building of Moos [Tower] and Phillips-Wangensteen [Building] and Lyle French's good relations with the Legislature. Given the extent of the health sciences expansion during the 1970s and the amount of money that French was trying to get from the state and was successful in getting from the Legislature, my sense of things is that there were some concerns about how big the Medical School and the health sciences were getting and there was some resistance from the Legislature. Can you comment on that?

JD: I think that goes on now. I think that may have been some of the force behind selling the Hospital to Fairview. I was not privy to most of that discussion. I'd just hear rumors. But I think there was an element in the Board of Regents that felt the Medical School was the tail and it was starting to disturb the dog. I think many of them appreciated that the Medical School was the main source of practitioners in the state. About fifty percent of the doctors in the state graduated from this school. This is a scientific center, a place they could be proud of for its scientific accomplishments. Yes, I think the Legislature had a very mixed feeling.

On the other side, the Medical School, I would say like the Arts, has an *unquenchable* thirst for money...the medical enterprise, not just the Medical School. The medical enterprise could spend limitless money doing things that you could argue were good. It's just not feasible. I think it's the same thing with the Arts. The symphony takes pride in having a deficit every year. I love the symphony and I hope it succeeds, but the thinking of those organizations, and the thinking of medicine in general, is we need money and we're going to put it to good use—and they're right! But the quantities are seen differently if you're the guy passing out the money.

DT: [chuckles]

You mentioned Ray Amberg earlier as administrator of University Hospital and that hospital administration expanded. I wonder if you could reflect at all on what happened once John Westerman took over that role and was Hospital administrator.

JD: John was much more *politically* oriented. Ray Amberg used to walk around the Hospital. One of his main things was if anybody was smoking there, he'd chase them out of the Hospital. He was a pioneer in the No Smoking Campaign.

DT: [laughter]

JD: John was a nice guy. I knew him pretty well. But he was a guy politically oriented here and there and a far more devious guy, I thought. Devious isn't quite the right word. There's a more polite word...figuring things out and expanding the administration. Yes, he was not universally revered, nor were his successors. It's been a succession of administrators that were regarded more as a source of conflict than a source of support through the years. That's a big generalization, but, in general, I think the Hospital Administration was not and is not well loved by the clinicians. They know they're necessary. Frank Cerra, for example, who was one of us and used to be one of my colleagues, is not well loved by all of the faculty. There's a guy who knew how to raise money, too. He was extraordinarily successful, I thought, in getting new buildings built. I think in that role, either hospital administrator or vice president, with every decision you make, fifty percent of the people are going to be mad, but it's a different fifty percent on the next decision. So, pretty soon, everybody is mad at you.

DT: [chuckles] Yes, it seems like a tough job to hold.

JD: Yes.

DT: In 1974, the Hospital got its Board of Governors, so it was under a different governance structure than just the Regents. Did that seem to change anything about the Hospital from your perspective?

JD: Well, I don't know. It provided an interface. I was on the Board of Governors, or maybe it was a subcommittee. It tended to be dominated by the Administration. We were there to argue with them or to accept, but not to originate ideas. They, literally, set the agenda. We'd have a brief encounter, and hear what they had to say, and agree or disagree. It was fairly congenial, but I don't know that it changed much. I think still, the Hospital Administration called the shots and these committees served some advice. It's not like the Board of Regents. I think they really make substantial decisions. I think the Board of Governors of the Hospital wasn't really making big decisions. We were advising and we'd vote, but it would be framed by a questionnaire where there was only one way you could answer it—and we'd say, "Yes."

DT: [chuckles]

JD: They were very good at controlling, I think. I don't know about the current circumstances, but they controlled us pretty well.

DT: What about Neal Gault? He was dean of the Medical School then in the 1970s and early 1980s? What was he like as a dean?

JD: Well, we all liked Neal *a lot* before he was dean and while he was dean. He was a very, very sensible guy who persisted in allowing leeway in the departments. He didn't try to dominate the school. He was a very good spokesman, a very good guy. Everybody liked him. He was very honest, very open. You could talk to him. We might disagree with him, but you could talk to him. Yes, he was very favorably regarded. I think the departments did think him a particularly good dean because he didn't try to interfere too much with departmental activities.

Now, Lyle tended to keep the thumb on Neal and just about did him in at one point. You may have heard that anecdote where Lyle suggested—I don't know how firm the suggestion—that a kid be admitted who was a *very* good student, a pre-med student, after his junior year instead of after his senior year. Do you remember that?

DT: I've seen some coverage of this, yes.

JD: Neal almost lost his job. Whoever didn't like him on the Board of Regents, and always you're going to have a few enemies, tried to get him fired because he gave preference to this guy who was the son of a politician. It was a terrible mistake on Neal's part, but I think he was forced into it by Lyle.

DT: I think John Arnold was the student's name. There was lots of coverage about it in the press and that that was a really contentious time. That's interesting that your sense of things is that it was Lyle French who was pushing for admission of this student.

JD: Yes, because he was the one that dealt with the father over in State Government.

DT: In the end, I think the student decided not to come or something.

JD: Yes, after all that newspaper publicity, I don't think he would have fared well here. It wouldn't have been a friendly atmosphere. I don't know what ever became of the guy in subsequent years. I think he did go to medical school. I don't know if he went here or not.

DT: I don't know for sure, but I think he was going to wait. Maybe I saw that he was going to wait until he was actually graduated and then come at the regular time or maybe he decided to go elsewhere.

JD: When I started, that was routine, three years pre-med. For me, there was a huge pressure to get done with college and get in after three years.

My number one consideration was not going to Korea. Many of my peer group were getting caught up and sent to Korea from college. That was the last thing in the world I wanted to do. Then, the other thing was, by those day's standards, it was expensive to go to Notre Dame. It was *very* inexpensive to go to the U of M. It was \$125 a quarter when I started. You could make that working as a laborer, which I did in the summer, and have money left over to buy lunches and gas and so on. Now, it's hopeless. You're not going to earn that. Maybe if you spent a couple years in investment banking, you could earn enough to do your tuition...

[chuckles]

JD: ...not laboring.

DT: The two years that you spent in the Army, was that required?

JD: By the Army, it was, yes. There was an interval there where the regular draft was over, but the doctor draft continued. So they got us. They called it the [Doctor Frank B.] Berry Plan. I didn't even know what it was, but what it says is, "You're going in the Army." Some people were able to evade it. I did my best, but I couldn't do it. Some people got very nice assignments in the military. For example, a few of them went to Walter Reed [Hospital] in research, but that was more in mid-residency. You were a third year resident. Rich Lillehei did that, I think. After a two- or three-year residency, he spent a couple years at Walter Reed. That was his Army... I did not have the skill or good fortune to have a nice assignment. Anyway, it was a big motivating factor. That, and money.



DT: What about David Brown? He replaced Neal Gault as dean.

JD: Yes. David was a good friend. I thought he was pretty effective. Not everyone shared that view. He was sort of a confrontational guy, talkative and forceful, but I thought he was fine.

In fact, I was on the committee that selected him. That was interesting in itself. I had a lot of fun on that committee. We had people coming in proposing that they be dean and you'd wonder a little bit if they were going to get the floor clean if you gave them a mop. They were people who couldn't do research. They weren't much good at teaching. They weren't good clinicians. They were, basically, nascent administrators and they said, "Ahh, the dean's job. That's for me." Honest to God, some were laughable. They'd come in and say why they'd be a good dean and you had trouble keeping a straight face.

We had one guy—I'm wasting your time with anecdotes—come to that committee from Stanford. He was a *very* famous investigator. He was in the pediatrics department. One of our criteria was the person should have had a foot in clinical and a foot in research to understand what was going on in the school and administer the school accordingly. He was very impressive in the interview, had a big record, a big bibliography, and some serious research successes, and a pleasant enough guy. So we called somebody at Stanford—I didn't do it personally, but I heard about it—and said, "What about...—I can't remember the name—"as dean?". "Oh, yes, he might be a good dean. He sure is a smart guy." It went on like that. "Does he get along...?" "I think he gets along pretty well with people." "Is he a good clinician?" There was a long pause. "A clinician?" "Yes, yes." "He's very active in pediatrics. He doesn't know where the hospital is," was the answer.

[laughter]

JD: We saw a lot of guys like that that posed, were good at interviews. We'd call the home base and they failed. You couldn't write. Letters of recommendation would always be good. They didn't want to get sued and the guy would be very careful what he selected to write on a letter. But if you called and you knew somebody, not the dean there, but somebody down the ranks you'd get the truth.

DT: You mentioned earlier that you ended up focusing somewhat on surgical oncology, at least doing breast cancer...

JD: Yes, breast, thyroid, melanomas, sarcomas. I gave a couple lectures on breast cancer when I was just starting. I think was to students and one was to Medicine. They said, "Oh, that guy is the breast surgeon." So they started sending me patients. By necessity, I had to learn a lot about breast cancer, because I got so many patients with the problem. That gradually evolved to where I had a breast clinic. I did have a lot of interest in endocrine issues, and I was the endocrine surgeon. So I ended up with that kind of thing almost by accident.

DT: It's interesting when thinking about the cancer field. There were so many different treatment modalities and it's maybe one of those diseases where it's unclear that you can pursue a surgical route, a chemotherapeutic route, or a radiation route. How collaborative was cancer treatment at Minnesota?

JD: It was quite collaborative. I dealt with B.J. Kennedy and with Sy [Seymour] Levitt. B.J. was head of Medical Oncology and Sy was head of Radiation Therapy. They were *very* nice, very easy to work with, and we got a lot of things done.

One disappointment was that the three of us were striving for a so-called breast clinic, a dedicated clinic with dedicated people, dedicated radiologists. We spent years working on that. The administration would say, "Yes, it's a good idea." They'd have another committee and that committee would say, "Well, let's see what our objectives are. What are our resources?" Pretty soon, you'd be falling asleep thinking about objectives and resources, but no clinic for the breast disease.

Then, when Todd Tuttle came as head of surgical oncology. I think one of his conditions for coming was that they *were* going to have a dedicated breast clinic; otherwise, he wasn't going to come. So he got that agreement. Even he then had a struggle to get it going. Now, it's outstanding, a wonderful facility, good volume with very good people. If you've got breast cancer, you couldn't come to a better place than that breast clinic. The whole deal is right there: the oncologists, the radiation therapists, the radiation diagnostics. It used to be you'd get an appointment a week later for a mammogram. Now, when you get the mammogram, and they say, "Do an MRI [Magnetic Resonance Imaging]." "That one's bad. We better biopsy." They put a needle in and biopsy. That's the afternoon and they're done. It used to be three, four, five appointments before you finally got a decision. It's an outstanding service. All the clinics should work like the oncology breast clinic. Many of them do. But that one is superior.

DT: Were you involved then, at all, in efforts to get a cancer center established?

JD: No. If somebody asked me, I'd say, "It's a good idea." I was not asked, nor did I participate in the organization. Ted [Theodore B.] Grage was really more dedicated to surgical oncology than I. He tended to get more disaster-omas. If somebody had a gigantic sarcoma or something, they'd tend to give him to Ted. He did quite a bit of melanoma work. He and I did a lot of the same things. He did quite a bit of esophageal cancer.

Oncology is an artificial discipline. It means cancer. Well, you can get cancer of the eyelids. You can get cancer of the nose...up and down the row. Well, which ones belong to an oncologist? Which ones belong to the ENT [Ear, Nose, Throat] or to general surgery, so on and so on. It is a good thing, but it's an artificial construct around a set of diseases rather than around a clinical discipline of diagnosis and treatment.

DT: Yes, or a specific set of organs.

JD: Yes.

DT: That makes sense.

JD: Right.

DT: Obviously, this was a difficult time for the Medical School and the Surgery Department. I'm wondering if you could share your perspective on the ALG [Antilymphocyte Globulin] situation that transpired in the early 1990s where Doctor [John] Najarian and his group's work with ALG came under scrutiny. I wonder if you have any perspective on that.

JD: Very much so. I'll have to restrain from vulgarity.

It's interesting you should ask, because just before I came to meet you, I was with Sy [Seymour] Levitt, who was, then, head of Radiation Therapy. He's retired; he does a little part time work. He's about my age. He's still just *furious* about this. He said, "A lot of bad things happened in this institution. The two worst were what they did to Najarian and what they did to sell the hospital." He said those two things brought us to what he sees as a sorry path. I don't see it necessarily that way, but he believes many of our difficulties derived from those two events, because it really did cripple a lot of things in the whole University to have that mess in the newspapers.

It started as a little note in the [*Minnesota*] *Daily* that the FDA [Food and Drug Administration] was wondering about ALG. Then, it escalated from there. Some of people that would like to bring the Medical School under control—this is all third, fourth hand and guesses—saw that and, yes, they can't do that. Really, they shouldn't be running a business over there; that's true. But, then, they started saying that clinically, it was bad and they were doing wrong things. Not so. The drug was outstanding. There were complaints around the country when it was taken off the market. It was a collaboration. The FDA had been here prior to shutting Najarian off from selling the drug. I don't think it was six months before, they had a team from the FDA come here and see how it was manufactured and *make sure* they could manufacture enough to meet the supply and demand. That was the truth. So the FDA was somewhat a collaborator and certainly knew about it. They just said, "You can't sell it anymore. You failed to fill out the papers," which was true. John had assigned a guy who was a nice guy, a smart guy, a very good investigator, but he was *not* organized and they didn't keep the data organized and recorded. It was a record keeping problem. Two things: they were running a business and there was insufficient record keeping. Those were the two complaints.

My impression was that the University Administration took that on with enthusiasm. I don't know exactly why, because it really hurt the whole University. I think it had to do with they were privy to all that was going on and they didn't want to be included as part of the attack from the outside. They were protecting their own posterior. That was a popular view and I think it's plausible. By so doing, they *really* screwed things up. They

spent five million dollars in legal fees to get Najarian, basically. The University attorney, who was supposed to be attorney for the whole University, was the attorney for the president [President Nils Hasselmo]. He, basically, was a personal attorney, as far as I could see, for the president in this situation and was a virulent attack dog through the whole thing.

John did plenty things wrong in record keeping, for sure. It was a terrible mistake on his part to entrust that to that particular person. They told him over and over it wasn't as though they suddenly missed the records. Each year, they'd say, "No. No. You've got to do better." I don't know how many years before they basically said, "Okay, you're done. You can't sell that anymore." Then, it just mushroomed from there.

I happened to have an occasion one time to talk to the judge. Sarge Kyle [U.S. District Court Judge Richard Kyle] is his name. He was the judge in the Najarian Case. This was three or four years later. I knew him a little bit. I resolved I wasn't going to inquire about that experience. Many of his quotes were in the newspaper. But he said, "Jack, what in the hell is going on at the University? What are they thinking of?" I said, "I don't know. You ran the trial. You must have gotten some insight." He said, "It's absolutely crazy. They spent all their money to get Najarian and they got themselves. They shot themselves in the foot. Worst of all," he said, "they, literally, made a federal case out of it." For God's sake, it's a record keeping failure. That's a federal case? Somebody is supposed to go to jail because they because they didn't keep the records right?" He was very critical about the University's behavior and very, very negative about the University's performance and said so in court, too, and made the newspapers on that, but the damage, by that time, was done.

John really screwed things up; no question about that. I think he'd admit it. But the way it played out was not rational.

One of the intriguing things juxtaposed to that issue was that, five years before, Stanford had a real scandal. They had a penthouse in New York and they had a boat on research funds. I don't know if you ever heard of that one.

DT: No.

JD: This was really outlandish the way they were spending research funds. They just circled the wagons. It wasn't the dean going after a culprit. They circled the wagons and said, "No, no, no. You're wrong. We haven't done anything out of order." Now, I'm really speaking out of school, but this was the way I heard it. They said, "You pick up a few little deals here, but no way are we agreeing we've done anything seriously in error. By the way, what do you think it would take to settle it? What kind of fine?" The FDA said, "Five million dollars." They paid the five million dollars and that was the end of it. I've over simplified it, but that's the story the way I heard it.

Here, just the opposite. The administration was going to get that guy, because we didn't do it. We're not responsible. They built a building using the ALG funds. They quizzed

the president about the building. Really? Oh. The ALG? Oh, my, that shouldn't have been done. They pleaded ignorance and he was ignorant enough, but what had been going on was the ignorance of how to handle it. The fact that's Moos Tower over here is a medical building...not Moos. It has the president's name...the Swedish scholar.

DT: Hasselmo.

JD: A building named after him, it's a sacrilege that they named a medical building after Hasselmo, who did more damage than anything in the history of the Medical School. It set us back years, with all that publicity. It was disastrous. But Najarian was by no means innocent of bad record keeping.

They went through something like two *million* records. They confiscated my computer. They wouldn't find anything on there, but they did.

DT: [chuckles]

JD: They came into the office unannounced, the FBI [Federal Bureau of Investigation]. I was there. They went in, the FBI, with their hats on, picking out computers and file cabinets and things. The Department was disrupted for a month, totally. So it was a federal case. The FBI had a lot of fun on that one. It was just insane. They went through all those records and never saw one cent that was misspent. Nobody took money home to pay their mortgage or to buy anything else. Not one cent out of the ALG funds was ever misspent. A lot of it was spent on a building for the University. We paid the salary of the professor of the History of Medicine, paid with ALG funds...Leonard Wilson.

DT: Yes.

JD: We paid one of the Hospital administrators whom we liked, who was friendly to the Surgery Department. His salary or half of his salary was paid from ALG funds. There were all kinds of things very supportive of the History Department and many other things that came out of those funds. The administration was very perverse and *very, very* unfortunate for the whole University.

Then, we had the white knight come in who is now head of Johns Hopkins, or he was. What is his name? I'll think of it in a minute. He came in. He was going to solve everything. He was the vice president for Medical Affairs. [Correctly, it was William Brody.]

DT: It wasn't [Robert] Anderson?

JD: No.

DT: [William] Brody?

The guy I'm thinking about was a radiologist and, then, he got into administration. He went to Hopkins as president of the whole University. I'll think of his name in a while. He came in right in the midst of it all. He didn't do anything so bad, as far as I could see, but what he did do is he agreed that we have to bring the Medical School, I think, under control. It's wagging the whole University. The way he was going to do it was he was going to get rid of tenure.

You're right; it was Brody. Yes, you're right. I was thinking of another guy who had been, I think, dean for a while. Probably, it was Brody.

And that was the end of him. In the whole university, tenure is sacred. Both sides of Washington Avenue suddenly had a common cause. Well, he got a good offer at Johns Hopkins, but I think his days were numbered once he started doing that, because the entire faculty, everybody but five or ten percent thought tenure was a good idea. They said, "We've got to get that guy out of here," and he left. Maybe he just got a better job.

DT: Do you get the sense that Najarian had a good amount of support among the faculty?

JD: It's Sy Levitt's contention, that there was a *lack* of support. The other guys didn't want to say... If I'm going to support him, they're going to fire me. I don't know that. But Sy supported him heavily and there were a number of others who supported him. He said that if they'd all got together and said, "No, you can't do this," and had a substantive threat, like we're going to quit.

DT: I know you said this was Sy Levitt's comment that selling the Hospital was the second bad thing that happened. What was your perspective on why the Hospital got sold and what the consequences were?

JD: I'll tell you what I thought the sequence was. They asked an advisory firm, one of the big ones, to come in and evaluate the Medical School and its future. My belief is they told them to come up with a conclusion that the financial future was dark. The Hospital was the one thing making money at that time. It was a profit center, not huge, but it was always profitable. I don't think it ever had a losing year. I, being a kind of conspiracy theorist, think those guys were instructed to conclude that the hospital was going to become a drain on your resources and it's going to start losing big money very soon. That scared the Regents. Then, they had all this previous trouble with the Medical School. The idea that they wouldn't be the owners of a hospital anymore, I think appealed to them.

There were agreements with Fairview for collaboration between the practitioners and the academics. It was a good idea; it didn't work. They didn't like it. Some of our guys went over there. There was always antipathy. I don't know how many private practice people remain in Fairview Riverside [Hospital]. A good many of them just left as the University became more involved. That proposed collaboration was, basically, a failure.

Now, in later days, Fairview is finally setting up true collaboration. They're making a single cardiology group out at Fairview Southdale, which I think will be a very salutary thing. It will be the practitioners...literally as a financial group, too, which is important, so they aren't saying, "These guys are getting paid too much" and so on. I think that's going to be a big boost to cardiology volume and to training and to everything else. So there may be good things coming of it.

At the time, I didn't know what the over all opinion was about the take over. I looked at it neutrally. I thought there were a lot of hazards. One thing I was very disappointed... Hospital administrators of the private hospitals understand the merits of efficiency to make money. There was no sign of that as Fairview took over. There was no evidence I could see that we were running a more efficient hospital and certainly weren't doing things that were going to bring patients scurrying in under Fairview's direction. So that was a big disappointment. We're going to do it this way, this way, and make it easy for the patients. We're going to satisfy the referring doctors. We're going to get it right. That didn't happen. They may have thought about it, but they didn't affect it.

I can't tell you what the over all opinion was. I think there was a good deal of suspicion. There wasn't a great love of the Hospital Administration at that moment either. It wasn't unmitigated opposition. It was sort of a mixed bag. Even now, if you ask people who were there through the whole thing, "What do you think?" A good many of them, particularly in Medicine, think it was salutary. In Surgery, I don't think it made a lot of difference. I don't know in other departments. Some totally moved over to Riverside and, obviously, find it a good thing. Orthopedics does most of their stuff over there. I don't know if Neurosurgery does. Obstetrics is totally over there. It disappeared from the University Hospital totally. Maybe that's a good thing. But it was a consequence of that ownership that various services moved on over to the other side. I think probably, on balance, it's a good thing; although, it's a logistic problem. You know the word propinquity. It's rubbing elbows and just brushing against, being near. You can't help but talk to them if they're standing there at the door...

DT: [chuckles]

JD: ...or you're sitting down and having coffee or something. It is defeated, in part, by the [Mississippi] River separation. We don't mix with orthopedists in the halls now, because they aren't there. Personally, I thought that is a loss. It's not disastrous, but it changes things. I remember we used to walk in the room of somebody doing an orthopedic procedure. Look at that. My gosh, look at that headlight. That's not a bad idea. Maybe I ought to get a headlight, so I did. Then, they had the room where the air blew out. They started putting artificial joints in. It was supposed to be a truly sterile room with rapid air circulation. Well, it didn't work out, but it was stimulating to the general surgeons to see what they were doing and vice versa. There was a lot of interplay just by being around. When they become physically separated, you talk to them, but it's not the same. I realized that in Physiology. I was mixed in there with all the physiologists. I'd go to the lectures and the conferences. I'd learn something. But the real thing that worked was to walk down the hall and what are they doing in there?

They're looking at blood vessels using a microscope right in a live animal. Wouldn't that be nice for us to do in our studies? All that stuff, just be walking around and mixing with those people, I learned a lot more than I learned in the lectures. I think that's true in a hospital, too. If you run into them, you talk. I always learn something and I always make it a point to go to lunch. Most of what I know about the current situation in the School and the Hospital, I get while eating lunch. [chuckles]

DT: [chuckles]

JD: Some positive, some negative.

DT: We've covered a lot of ground. I wonder if you have anything else that you want to share about your perspectives on the history of the Medical School.

JD: Well, it *ain't* what it used to be. I think the numbers show that. I don't know the reasons. We're suffering dollar constrictions that aren't likely to get better. I don't know what to do about it. We aren't alone. All around the country, they're experiencing a similar thing—as are the undergraduate students with ever-mounting tuitions. We're paying increasing shares of the clinical income for things other than support of the clinical work. There are a lot of problems that didn't used to exist. I don't know if there's fault or praise to be dealt out. It's definitely not what it used to be. When you talk to people nationally, they tell you the same thing. We were extremely prestigious in the 1950s and probably through the 1960s. Gradually, that's deteriorated. Certain departments still are very prestigious. For what the rankings are worth, we're kind of middling among the state universities. Maybe we're in the upper third, but not at the top of the state university hospitals. I don't know all the explanations. Money is one of them, but there are probably other things, as well. It's still a very good place. I'd be happy to be a resident here and happy to be a student here, but I would not have the same level of pride that we had as students. Maybe that will change, but the impediments are many.

DT: Thank you. I've really appreciated your perspective. It's very valuable.

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