

Alfred F. Michael, M.D.

Narrator

Dominique A. Tobbell, Ph.D.

Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

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

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

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

Biographical Sketch

Alfred Michael was born and raised in Philadelphia. He earned his undergraduate and medical degrees at Temple University in Philadelphia. Dr. Michael completed a portion of his residency at Philadelphia's Saint Christopher's Hospital for Children before he was inducted into the Air Force under the Selective Service Act of 1948. After he completed his military service, Dr. Michael returned to his residency in 1957, this time at Cincinnati Children's Hospital, ultimately specializing in pediatrics. Dr. Michael then served as chief resident and instructor in pediatrics at Cincinnati until 1960, when he came to the University of Minnesota as a fellow to work with immunologist Dr. Robert A. Good. From 1966 to 1967, Dr. Michael spent eighteen months in Copenhagen doing kidney research on a John Simon Guggenheim Fellowship. In 1973, he became chief of the Immunopathology Laboratory. He became a Regents' Professor and head of the Department of Pediatrics in 1986. Then, in 1997, Dr. Michael succeeded Dr. Frank Cerra as dean of the Medical School. Dr. Michael resigned as dean in 2002.

Interview Abstract

Dr. Alfred Michael begins his interview with a reflection on his childhood and education in Philadelphia and his interests in medicine and pediatrics. He describes his decision to move to the University of Minnesota in order to work with Dr. Robert A. Good. He then discusses all of the following in relation to his research: working with Robert Vernier; changes in technology and methodology related to testing the kidney; his graduate work in biochemistry; specialization in medical research; work on transplantation and dialysis with John Najarian and Carl Kjellstrand; kidney research at the University; the expansion of and coverage for dialysis; and his time in Copenhagen. Dr. Michael then describes Dr. John Anderson's tenure as department chair and his own tenure as dean, during which he made efforts to create a major children's hospital facility in combination with the University. He also reflects on the larger context of changes in healthcare structures in the period, particularly the emergence of HMOs and Minnesota's role in the development of HMOs, and town/gown relations in the Twin Cities. Dr. Michael then discusses Robert Howard and David Brown's tenures as dean of the Medical School and issues with private practice and finances at the University. Turning to administrative matters, Dr. Michael describes his work with Win Wallin; William Brody's tenure as provost of the AHC; and the growth of the administrative power of the AHC. He then elaborates on the creation of University of Minnesota Clinical Associates and University of Minnesota Physicians; the sale of University Hospital to Fairview; divisions of responsibility and administration within the AHC; relations between different schools in the AHC; and the investigation of John Najarian in connection with Antilymphocyte Globulin (ALG). He concludes with reflections on the balance of research, teaching, and clinical work; his moves into administrative positions; his work on various boards; his work with the Legislature; and the Medical School's standing.

Interview with Doctor Alfred F. Michael

Interviewed by Dominique Tobbell, Oral Historian

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

**Interviewed at the Home of Doctor Michael
Saint Paul, Minnesota**

Interviewed on April 25, 2012

Alfred Michael - AM
Dominique Tobbell - DT

DT: It's Dominique Tobbell and I'm here with Doctor Alfred Michael. It's April 25, 2012, and we're at Doctor Michael's home.

To get us started, can you tell me a bit about where you were born and raised?

AM: I was born and raised in Philadelphia, and I spent the first twenty-five of my life there.

DT: What led you to go into medicine?

AM: From the time I was six or seven years of age, I wanted to go into medicine. There was never any other realistic goal. I never wanted to be a fireman or a policeman. Medicine was of great interest to me. I'm not sure exactly where it all came from. I believe my father had some role in that, because I recognized quite early that he often said, "I wish I had had the opportunity to go into medicine." So that was the framework in which I developed my interest and that kept being rekindled throughout childhood and adolescence. So there was never any question through high school or whatever. That's what I wanted to do.

DT: Where did you do your undergraduate work?

AM: I did my undergraduate work at Temple University in Philadelphia after receiving a scholarship and went from there to Temple University School of Medicine.

DT: Where did you take your residency? Was it in Cincinnati [Ohio]?

AM: Yes, most of my residency was in Cincinnati. For a short period of time, for about six months, I was a resident in Philadelphia at a place called Saint Christopher's Hospital for Children. After that time, I was inducted into the U.S. Air Force as part of the so-called *Doctor Draft*. Then, when I left the military after two and a half years, I went to Cincinnati Children's Hospital.

The leader of Saint Christopher's program was a person by the name of Waldo [E. "Bill"] Nelson. He had written the most outstanding textbook of pediatrics. He had previously been at Cincinnati and that was the reason I went to Cincinnati; I knew that Bill Nelson had been a faculty member there before he came to Philadelphia.

DT: So what led you to specialize in pediatrics?

AM: I think there are probably multiple reasons, but the most important is an affection for kids. That is the golden thread. If you talk to pediatricians and ask, "Why did you do this?" the answer is that they like children. You connect with them.

DT: What was your experience at medical school like? Was there anything memorable about your time at Temple?

AM: My parents had limited resources but did everything they could. I had opportunities to go elsewhere, but I never applied to any other medical schools. I was able to get a scholarship, actually through college and medical school, which helped with a lot of the finances.

I spent a good part of those years living at home and commuting by bus and trolley, et cetera. Again, because it was cheaper than to trying to live away.

DT: That makes sense.

Was there anything notable about your time at Temple, any faculty that stood out or any experiences that stood out for you?

AM: What stood out during medical school was Bill Nelson, who was the head of the Department of Pediatrics, so I became connected during my school years. This influenced me; that led me to go into pediatrics as a career, actually.

DT: Once you'd completed your residency at Cincinnati, what led you to come to Minnesota?

AM: At Cincinnati, where I stayed on as chief resident and instructor in pediatrics, I decided I wanted to come to Minnesota, to work under Robert [A.] Good who was an outstanding pediatric researcher in Minnesota, at the time, doing creative investigations in immunology. I believe, even today, if you look back over the outstanding faculty that

Minnesota has produced, Bob Good would be at the top or very near the top. He was an outstanding scientist, ultimately ended up having his picture on the cover of *Time Magazine*, and was very, very well known. When I was in Cincinnati, I came to Minnesota to visit with him and he said, “Oh, yes, you can come up.”

Then, a short time after that, he called me and said, “I’m thinking of going to New York. I’m not sure what’s going to happen. I don’t think I’m going to stay at Minnesota.”

I had previously thought about going to the University of Washington in Seattle. So I had negotiations with them and decided, yes, I’m going to go to Seattle, Washington. That was about six months before I was ready to leave to go to Seattle, and I had already accepted a position there. I heard that Bob Good was *not* going to go to New York, but I figured it was too late, and I had already made arrangements to go to Seattle. I didn’t feel good about not going.

At that time, I was at Cincinnati Children’s Hospital, and one night after I had a late dinner, I came out of the doctor’s dining room and looked down the hall, and there was Bob Good from Minnesota. He was down to Cincinnati for a meeting. I had not talked to him at all since the preceding year. But at that time, I knew that he was not going to New York. I remember thinking to myself, what I decide to do in the next thirty seconds is going to influence my whole life. I saw that very clearly. I walked up to him and he said, “Oh, hi, Al. You’re coming to Minnesota, aren’t you?” I said, “No. I have an appointment at the University of Washington.” He said, “You don’t want to go there. You come to Minnesota. I’m in Minnesota.” That’s how I got to Minnesota.

DT: Wow.

AM: Quite a story.

DT: It is.

AM: But what is unique about the story is that in the period of a minute or two, you recognize that you’re going to make a decision that will affect your entire life. But obviously I wanted to come to Minnesota to work with him.

So I came to Minnesota for two years, initially, and never left, and that was in 1960, fifty-two years ago.

DT: [chuckles] You must have liked the place.

AM: Yes. Oh, Minnesota is a great spot. It’s a great state. The University is a wonderful institution. I always feel that the University doesn’t owe me anything; I owe the University tremendously for my own career here.

DT: Were there any repercussions from not going to Washington?

AM: Oh, there were. A few words were passed but those things blow over. I wrote them a note saying what had happened. They weren't happy about it, but things like that happen. The net effect is that, had I gone to Washington, I'd have had a different type of career, I think, in a different part of the world. Perhaps working on things that I worked on here, I would not have worked on in Seattle. But that blew over. There was no problem. I felt funny about it for a while, but I thought it was the right decision, ultimately.

DT: When you first got here, what did you do in those first couple of years? What were your responsibilities?

AM: Here, I was mainly a research fellow. We did clinical work but mainly research. Good's principle advantage, I think, was he was very innovative, a very creative scientist. He had had an M.D., Ph.D. degree from the University of Minnesota and ended up a world-class scientist. He came close to getting the Nobel Prize. He left Minnesota a number of years later to go to [Memorial] Sloan-Kettering [Cancer Center] in New York. His career thereafter didn't go as well as he would have liked.

In fact, he had taken with him a dermatologist [William Summerlin] whose research in skin transplants was widely criticized. He was transplanting black skin onto white mice. This was devastating for Bob Good's career, as it turned out. He left Sloan-Kettering thereafter and went to Oklahoma, ended up in [Saint Petersburg] Florida at All Children's Hospital for the rest of his career. In retrospect, it would have been better had he stayed in Minnesota.

Nonetheless, I became interested in the kidney. There was a creative physician scientist here by the name of Robert Vernier. He was a close colleague of mine for the rest of my career, who was interested in kidney disease. He and I worked together thereafter. So for the next thirty-five years, Bob Vernier and I worked together. It was a good interaction and we developed a very strong kidney disease group in Pediatrics. It ended up being the premier children's kidney research program in the world for quite a number of years and led to the training of over one hundred fellows.

DT: Why the kidney? What attracted you to it?

AM: The challenge was to figure out the pathogenesis of the various forms of kidney disease in children. The ability to do this involved kidney biopsies. Bob Vernier did one of the first kidney biopsies on a child. Then, it was the advent of ways to look at the kidney using microscopy and electron microscopy and other modalities. My major interest was to understand how the kidney is injured by immune mechanisms. I was one of the first that used immunochemical technology on the kidney. We did one or two reports. We developed all the systems to do that for years and that lab is still going strong here at the University. [chuckles]

DT: Can you elaborate a little bit more on what some of those tests were that you were doing?

AM: Yes. For example, it was possible to sort out the various forms of immune mediated glomerulonephritis, which for years were lumped together as nephritis, also called Bright's disease. There had been previously no clear differentiation of the various types of kidney disease. The kidney really had an advantage because one could obtain tissue to study it.

What we did was look at it from a variety of different methods: microscopy, electron microscopy. We developed a variety of immunofluorescent probes and antibodies. So we did some of the first work on nephrotic syndrome. That eventuated into looking at various forms of familial renal disease, such as Alport syndrome. That approach led us to look at the antigenic diversity, like crucial components of the glomerular filter, mainly the glomerular basement membrane and mesangium. So we are able to study the types of collagen in glomerular basement membrane and to sort out what was going on in the various forms of nephrotic syndrome in children.

Those studies, I think are part of the golden thread that went through our research over a period of four decades.

DT: Were you also doing graduate work in biochemistry at the time?

AM: Yes. In fact, when I came to Minnesota, since I always loved chemistry and biochemistry, I decided to take all the graduate biochemistry courses. I had an advisor, Cy [Cyrus] Barnum and was a Ph.D. candidate.

But, while that was going on my research was focusing on the immunobiology of the kidney. The biochemical studies turned out to be ideal because these gave me a lot of information that I needed to do kidney work. I was going where my passion was. So I decided not to go ahead and do a thesis. I had enough of the graduate work in biochemistry to help feed what I needed to know for the studies I was doing.

DT: Too bad you couldn't have used the research you were doing in immunobiology for your thesis.

AM: In retrospect it might have worked, but I thought it would be distracting.

When I was here at Minnesota for a few years, I was awarded an Established Investigatorship from the American Heart Association. I went to Copenhagen [Denmark] with my family for eighteen months. I started my work on basement membranes and ways to isolate crude basement membranes there.

After returning to Minnesota, we studied the immunochemistry and the biochemistry of basement membranes. The focus was on abnormalities in the kidney that induced disease in children. We used whatever methodologies we could to figure out some of those diseases, like nephrotic syndrome and glomerulonephritis, and various forms of glomerulonephritis.

DT: That approach of focusing on the organ and focusing on the diseases of the organ and then studying it, as you say, with whatever methodology was appropriate, was that a common practice within medical research, at that time, or was this something a little distinctive?

AM: No, I don't think that was unusual. The initiating question was essentially asked by the patient with kidney disease. This sparked the research effort. It was beginning to happen then in the 1960s. When I started work on the kidney, there was no subspecialty of nephrology. It wasn't even named.

Specialization, however, was a natural evolution, because the amount of information was great. It was expansive enough if you are concerned with a specific organ such as the kidney. So your focus is ultimately on the patient and the disease process. So that's what led the way for me.

There was another therapy that began to increase in frequency in the 1960s, and that was dialysis. Then the development of transplantation was a game changer. The kidney was central in this process of developing transplantation, both from an investigative point of view, but, also, this was the era when you could take somebody who was dying of kidney disease and give them a new kidney. Because we had a program in nephrology for children, there was a logical connection for John Najarian and his expertise to develop the program for kids. Most other places in the country, at that time, were doing mainly adults, but Minnesota was doing a lot of kids. Minnesota became well-recognized, not only for pediatric kidney disease, but for transplantation biology nationally, a great era. That was before there were any major pediatric programs in most places in the United States.

DT: Was there anyone working in adult nephrology that you were working with at Minnesota?

AM: At that time, yes. There was Carl Kjellstrand who was running the dialysis unit. Actually, he was an internist in the Department of Surgery. The surgeons needed to have dialysis, and it was not developing very well in the Department of Medicine, at the time. Carl really got that dialysis program going. Mike [S. Michael] Mauer, who initially was one of our fellows and, later, became a faculty member and world class investigator in diabetic kidney disease, worked with Carl and developed a lot of the strategies and equipment for dialysis in children since those things weren't well established. Minnesota was at the forefront of dialysis and transplantation for children.

DT: You mentioned nephrology was emerging as a subspecialty. That was in the 1960s, also, that it was established as a subspecialty?

AM: Yes, the development of the subspecialty, nephrology, was largely stimulated by dialysis and transplantation, even though for many years there were physicians who focused their clinical and research efforts on the kidney. There was a lot of focus. And

because of what developed—I can't give you the precise year—over the course of the 1960s and 1970s, even the Federal Government agreed that they would pay for dialysis through Medicare.

DT: I think it was either 1972 or 1973 that...

AM: Yes, just about that time.

There was a program at Hennepin County Medical Center, which was a good program. It was mainly dialysis related, so they had a substantial adult dialysis program at Hennepin County at that time, and I think Mayo [Clinic, Rochester, Minnesota] was doing somewhat the same thing. But the children were mainly here at the University, because we had this big program. We were training a lot of fellows for the nation, at that time.

It wasn't too long after that Jean Hamburger at the Necker Hospital [Hôpital Necker-Enfants Malades] in Paris [France] coined the term *nephrologie*, so that became the word nephrology. Now, we had a name for people who dealt with kidney disease: nephrologists.

There'd always been people interested in the kidney. It came from a variety of disciplines, some from endocrinology, some very much interested in fluid and electrolyte balance, because the kidney is so important as the *master chemist* of the body. They were called the *salt-water boys*, at the time.

[chuckles]

AM: Then that all merged. There are still people in nephrology who are interested in salt water and fluid and electrolytes. It's a major staple of the discipline of nephrology.

It was an evolutionary period. I took over as head of Pediatrics at the U in 1986, and I maintained that until I became dean of the Medical School in 1996. At that time, the head of Medicine was a nephrologist, Tom Ferris, and the head of Surgery was John Najarian, who was interested mainly in kidney transplantation. Then I became head of Pediatrics in 1986. The three chairs of the Departments of Medicine, Surgery, and Pediatrics were mainly interested in the kidney. That came about because of this great interest in nephrology, here, from a variety of different disciplines.

DT: It sounds like there should be a statue of a kidney somewhere.

AM: Somewhere along the line, it had an influence on the recognition of the University as being a place for people interested in kidney disease.

DT: Do you recall when either the University, or the Department of Pediatrics in particular, got your first dialysis machine?

AM: In the early 1960s, Milton Reiser in the Department of Urology was running a small dialysis program. Dialysis really got going once transplantation had started. There had been kidney transplantation prior to John Najarian coming to Minnesota, under Dr. Bill [William D.] Kelly and others in the Department of Surgery [Drs. Jos Aust and Richard Varco].

DT: I know in other institutions—one I'm thinking of might have actually been either in Oregon or Washington—when the dialysis machines were first introduced, they were in such high demand that there were committees at the hospitals who decided how to prioritize who got the dialysis.

AM: Yes.

DT: It sounds like by the time dialysis was really gaining a hold in Minnesota, it was already being covered by Medicare, so there was more technology available.

AM: I know initially Medicare wasn't available for that. That would have been, I don't know, the early 1970s, I think, when that became available after congressional lobbying.

DT: Who was lobbying? What were some of the groups?

AM: I'll tell you the person who could give you the most information on that would be John Najarian. I know he was involved in that for obvious reasons. If he didn't have good dialysis, he couldn't have a good transplant programs.

At Hennepin, there was a chronic dialysis program. Initially patients were on dialysis and never got transplanted. They were just chronically dialyzed. The question at the time...well, they're going to be on dialysis the rest of their lives. They may have wanted a new kidney, but you have to have a system to get the new kidney, and if you transplant a kidney in and it doesn't work for a while, you have to have dialysis to keep them alive. That gradually worked its way out with federal funding and, then, the dialysis centers all over the country came up and they still exist to varying degrees. Generally, the goal was to get them a kidney, not be on chronic dialysis forever. That's certainly the case for children. But some people can't be transplanted for technical or immunological reasons and end up with chronic dialysis.

DT: When you arrived in the Department of Pediatrics, you were a fellow. Your appointment was in the Pediatrics Department, and, then, were you eventually appointed as a faculty member in the department?

AM: Yes. I wasn't too interested in even being a faculty member. I was doing research. I was a fellow. I had this five-year thing with the American Heart Association, the established investigatorship. I think they carried me as an assistant professor. I still saw patients. I still did clinical work and teaching, but I gave a lot of my energy to research during that era.

Then, I went over to Copenhagen for eighteen months to do research. When I came back, I had offers to go elsewhere, UCLA [University of California, Los Angeles], et cetera. They wanted me to stay in Minnesota. It was at that time, also, about 1966, Bob Vernier went to California with Bob [Robert] Ulstrom, who had been in endocrinology at the University. Ulstrom went to California as head of the Department of Pediatrics. That must have been in 1965, approximately. Vernier went there and stayed there several years. When I came back, they tried to get me to go out there to California. But I decided I wasn't going to do that. So I came back to Minnesota.

John Anderson was head of the department, and I got to be an associate professor, I think. I was never sure whether I was instructor or assistant professor. I never paid any attention to faculty rank. It wasn't that important to me, at the time. So that was about it.

DT: I've heard of other people who went to Copenhagen in this same period of time as you. What was the appeal of Copenhagen?

AM: You've got to realize that in the early 1960s, Europe was divided. There was East and West Germany. The wall was up. If you traveled from West Germany to East Germany and the train stopped, soldiers got on with machine guns. It was a dreadful time to really live in, so people went to either England or Scandinavia...probably today, more often to Stockholm [Sweden], I think, where I ended up going back a number of years later. There was generally a good feeling about relationships in Copenhagen. Some people had gone over there for a year or two in a special area and they encouraged other people to go. So I went over. I think Bob Good was the guy that advised me that I should look over there. I had a good year there. It was entirely doing research.

Then, when I came back and Vernier had left, I was in charge of nephrology at that time, 1966. Then, Vernier came back after several years. He and I worked together running that program, which, then, became a very big program. We had many fellows and there was heavy NIH [National Institutes of Health] support. A lot of research was going on. It was a great time.

DT: In those early years, Irvine McQuarrie was department chair, if I understand it right?

AM: No. McQuarrie had been the department chair. I came to Minnesota in 1960. McQuarrie had, I think, left in the late 1950s, and John Anderson was the head of the department. He stayed head of the department until 1975.

DT: What was he like as the chair?

AM: He was a gentleman. He was very interested in philosophy and he loved to talk. He wasn't an activist. His major achievement was that he was permissive. He didn't try to dictate to anybody, "You should do this," or "You should do that." Some people would criticize him, "You're not decisive." But his advantage was he let people work out their own lives, as I look back on it now. So I think, during that era, it was important that people use their own initiative and their own imagination as to where they wanted to go

and what they wanted to approach. He was very supportive of that. He didn't compete with his faculty members. So many leaders, whether it's institutional or otherwise, or if they have young people working with them, will compete with them, which is the kiss of death, actually. John never competed with anybody. That's the general perception of John. You'd go in to talk to him, and he loved to talk. It was usually on some very esoteric subject that didn't bear any relationship at all to the subject at hand. He was a very well read guy. He was a nice man, I think.

During that era, we were going through some major problems with respect to the building of Children's Hospital in Minneapolis. I think if there was a problem, John didn't really appreciate the potential of bringing the University and Children's Hospital together. John didn't feel that was important or feasible. Another fact is that people who started Children's Hospital were remote from the University and it led to competition in the long run. Arnie [Arnold] Anderson, a pediatrician in Minneapolis, and Tague Chesolm, a pediatric surgeon, worked with community leaders to establish Minneapolis Children's Hospital. [pause] There was a view that it would be good if the University and Children's could come together in some way. I'd been to Cincinnati in which everything was connected at Cincinnati Children's Hospital and Cincinnati's Medical School for the whole community, essentially, the whole southern part of Ohio actually, and it was magnificent, because they were able to do all sorts of things, connect with people, wonderful fundraising mechanisms that led to the development of research institutes and so forth. But here, we were splintered. There was a University Pediatric Department and a Hospital and the pediatricians in the community didn't refer patients to the University. They referred them to all the little hospitals in the community. If they were on the staff, they sent their patients over there. The only thing they would send over would be something that was very complicated or they'd send them to the Mayo.

Tague Chisholm was one of the first pediatric surgeons. He was trained in Boston and came to Minnesota. Tague tells an interesting story that when he came to Minnesota, he stopped by to see Owen Wangenstein, who was head of Surgery. Owen Wangenstein said, "Oh, we don't need pediatric surgeons here." Essentially, that was what Tague heard, but I am not privy to that conversation. Tague was now trying to do surgery at a smaller hospital, which he couldn't do, because they need very good anesthesiology and centralized facilities.

DT: I spoke to Arnold Anderson about two years ago now.

AM: I always had good relations with Arnie Anderson.

He and Tague with people in the community got together about building a children's hospital. They were not connected with the University. At the University, there were some who looked down on this venture. The net effect was the development of Minneapolis Children's Hospital. Arnie Anderson said to me, "You know, Al, if you'd been head of the department then, it would have all been together." It was the old structure. So they developed Children's Hospital and the two children's hospitals were

small, one in Saint Paul combined... Actually, I was on the Board of Saint Paul's Children's at the time and tried to talk them into combining with the University.

When I became head of Pediatrics in 1986, I decided, I'm going to lead an effort to combine the hospitals into one major children's facility. I gave, over the next nearly ten years, a lot of energy and effort to get that done, to try to get them merged into one major children's facility which would be community-based, but would be the academic part of the University Hospital.

Now, while all that was going on, there were major changes in healthcare in Minnesota. I was president of the American Society of Nephrology, which is the major kidney disease organization in the world. In 1992, I gave my presidential address at that time, and spoke about healthcare in Minnesota and the HMO [Health Maintenance Organization] movement, looking at different systems for healthcare, which involved access, cost, and quality, problems we still have today. Minnesota became a leader. This is the time when [President Bill] Clinton was trying to get a healthcare plan through war congress in 1992.

I'll never forget—I think it was in the late 1980s or very early 1990s. There was an organization that visited to look at the University Hospital. The HMOs were not allowing patients to come to University Hospital and insurance companies weren't paying. I'll never forget the leader of that organization coming into a meeting. He said, "I want to let you know where the University Hospital is. It's ten minutes before midnight." I'll never forget what he said about that. That's how serious the problem was.

That was part of the revolution. University Hospital was sold to Fairview Health Systems in spite of the concerns of many physicians.

Just when that happened, I was in discussions with the people at Children's Hospitals over the past year about merging University and Children's. The discussion ended. The Hospital was bought by Fairview, which did not have a substantial pediatric program, but looked on getting the University's pediatric program as part of its major acquisition. I won't go into all the details, but there were a lot of discussions with the boards, the Children's Hospitals, et cetera, that I had during that time. It went down the tube, essentially.

It reappeared here about, what, five, six years ago and still was not successful. What happened was that the two health systems, Fairview and Allina, each wanted control of their pediatric programs. So the thing didn't come together because, essentially, the major players didn't want to give them up, didn't see the vision of bringing them together. It was a wrong decision in my view. Someday, they'll get together.

So I worked on that for a long time. That's one of the things that I guess I got involved with respect to where pediatrics is going on, where children's healthcare is going. The net effect is we could have had one of the premier, unified children's hospital in the world, and we don't have it today.

DT: When you have children's hospitals that are attached to academic centers, those are generally more encompassing. They include community and academic practice?

AM: Yes. That's the advantage. It incorporates the community with the academic, scholarly research piece of it, and education. So it's a healthy and productive union for all. There are plenty of models. You can look at Boston Children's, Philadelphia Children's and Cincinnati. Now, a lot of hospitals and academic health centers are calling their pediatric departments, "children's hospitals," because of the appeal of that term. Here, we now have one at the University and, Minneapolis and Saint Paul are together. We have Shriner's Hospital, Gillette Children's [Specialty Healthcare], so we have a lot of separation going on.

DT: The Amplatz Children's Hospital was just opened in the last couple years.

AM: Yes.

DT: Where does that fit in the scheme? That's the University Children's Hospital.

AM: I think it's a great institution. Kurt Amplatz was a wonderful guy, a radiologist, and very innovative. He got involved with industry and developed heart valves and made a lot of money. His daughter [Caroline Amplatz] and he, then, arranged for a big gift [\$50 million] to the University Hospital—actually to Fairview Health Systems—to build the children's hospital.

That's when the most recent discussions about a merger came up, but it could not really be worked out for one reason or another. Ultimately I believe that a merger of Children's Hospital of Minnesota with University of Minnesota Hospital will occur in some form. It's a matter of time. That's the way it goes in life. Sometimes, you have to be patient.

[laughter]

DT: Yes. I'm glad that you brought up the efforts to establish the children's hospital in the 1960s, because I had interviewed Arnie Anderson, and he had mentioned the reluctance of John Anderson, particularly, to the efforts. It's striking that, even though John Anderson was opposed or uninterested in merging, that maybe some of the faculty members like yourself thought it was beneficial.

AM: Oh, yes. There were some that were opposed to it. I was four-plus for it and tried to do everything I could. Actually, I developed a good connection with Arnie Anderson from that. When I became head in was it 1986. I was talking at children's hospital board meetings about a merger. Some of the board people at Minneapolis Children's and their administrators and the administrators [such as Greg Hart] at the University Hospital, we were meeting about how to do it. I was having meetings with the physicians at all the institutions to try to get it done. It wasn't in the cards, at the time.

Then, there was a second attempt here more recently before the current University children's facility was built. There was discussion then. That would have been in 2000 or 2001 or 2002 when I was dean of the Medical School. I was trying to push it from the Fairview side, at that time, so I was back talking to people again. There wasn't enough push from it. It was never clear. The institutions Fairview and Allina Health Systems—Minneapolis Children's was a separate institution with allegiance to Allina— could never fully agree. There were physicians who were opposed to it because they felt that they were going to lose out on programs. It would have taken a major push to do it, and the push wasn't there. The Academic Health Center was under Frank Cerra, who was not a strong advocate.

DT: It sounds like, particularly in the 1960s as you describe it and maybe continuing through now, that those tensions between the University physicians and the community physicians... In the 1960s, it seemed like, even beyond Pediatrics, there was so much town/gown tension.

AM: Oh, yes. That's historically been a major fault in Minnesota, the town/gown problems.

In the late 1980s, I can remember going over to staff meetings at Minneapolis Children's trying to talk to them about coming together. A lot of energy was given to it, but people weren't ready for it. Will it ultimately occur? Yes. As you build new hospitals and so forth, everybody builds more super structures, and it interferes with community physicians and University connections. I think it has a profound effect on resource development. Having a major university-community children's facility here, you enlist connections with other children's programs.

DT: It sounds like it would create, potentially, administrative efficiency, too. Rather than having three different children's hospitals, you've got one coordinating system.

AM: Yes.

DT: You eliminate some of that redundancy.

AM: It's a competitive marketplace. People then are working for an organization, which is competitive. Our current healthcare system sets the stage to get more patients, more resources, build more buildings. It's all changing. It's going to change profoundly, I think, if Obama Care [the Affordable Care Act] succeeds, and it has to succeed. We can't have 45 million people without healthcare or insurance. It's not salvageable otherwise.

DT: Did you perceive those same town/gown tensions at Cincinnati?

AM: Essentially minimal, but there is never complete harmony! The community physicians admitted patients to the children's hospital, and the faculty then helped take

care of them, so it was *community* connected. The community physicians were an integral part of the faculty and worked together.

It's similar to the problem the Catholic Church is having today. There's this disparity between the in-house bishops' leadership and the people. People have a minimal role in governance, for example, so they give less money. It has profound effects on the system.

This would have been an appropriate connection, because the community and the academic institutions need to get closer together, because that's where the money comes from. That's where the patients come from. It's the best for education and research.

DT: Do you have a sense of why Minnesota town/gown relations were so pronounced?

AM: I don't know. They were there when I came here in 1960. There has always been... I think part of the problem was that the community medical system...the physicians in practice were not on the staff of the University and had no admission privileges. It limits its scope and size, in a sense, and you have separate systems. The physicians in community-based programs have loyalty to the program. That's where they take care of sick people. That's where they work. That's what they give money to. And over here, at the University, you have a completely different system and a chasm between the two, so they don't come together.

Some would argue, it's okay. It doesn't matter. Let them be separate. We'll still give good quality medical care. There's some truth to that notion. I think you can give very good care at two different institutions. I think the quality of care, for example, at the community children's hospitals is as good as the quality of care at University. But it's not as good from the point of view of fundraising, building community interactions and consensus, providing other related organizational structures, and developing comprehensive, unified healthcare—especially in the wake of the Affordable Care Act and the need to provide access to quality healthcare and reduce costs.

DT: Changing topic a little bit... During the 1960s when you arrived, Robert Howard was dean of the College of Medical Sciences. I wonder if you had any sense of how his leadership affected the school.

AM: Bob Howard... You probably know the story on that. The way it worked when I came here was that the chiefs of the clinical services really ran the medical institution, especially surgeons but also others. So you had very strong people here with Owen Wangenstein [Surgery], Lyle French [Neurosurgery], Donald Hastings [Psychiatry], Dick [Richard] Varco [Cardiovascular Surgery], Walt [C. Walton] Lillehei [Cardiovascular Surgery], Cecil Watson [Medicine], and Bob [Robert] Good [Pediatrics]. So the leadership was often within a surgical discipline and all were in private practice from which they received most of their income. So whenever there was an issue of a new dean being selected, the question was, "How will this affect private practice?" Now, the private practice independent fiefdoms controlled how much money the physicians made. The dean didn't have a significant role in that, in that arena. They would set a base salary

that was small, usually, because that's all the institution had to give. The argument was, "Well, the institution is not giving me money. I have to work hard to bring in extra dollars. So why shouldn't it belong to me or belong to the department?" That doesn't bode well with the idea that it's coming from the institution. You're a University physician. I don't care how much the University gives. Appointment of head of the department or professor, that's the University. That's the State of Minnesota. But in effect, it meant that the dean had limited power over resources. Bob Howard ended up being a *weak* dean, not because he's a weak person but the circumstance was that he really didn't control resources.

There was a slow transition, spanning several deans to get to the point where the dean could make decisions about salary.

There had been this whole thing called the Najarian affair, which I'm sure you've heard about.

DT: Yes, but I'd also love your perspective on it.

AM: Yes.

As far as the deanship was concerned, it was Bob Howard, and, then, Neal Gault. Then Dave Brown came. I chaired the search that led to Dave Brown being dean. That would have been in the mid 1980s.

I was chair of the search committee, and I walked in one morning and noticed everybody was already there. I sat down, and they said, "We've decided with you out of the room that we want you to be dean." That was Gene [Eugene] Gedgaudus who was head of Radiology. I said, "You've decided that? I thought I was chair of the committee." "Oh, no, we've decided to settle the whole problem right now." I said, "Let me tell you something. I don't want to be dean, and I'm not going to be dean. So let's get back into the meeting."

[laughter]

AM: Dave Brown became dean. He did an excellent job, initiated the Institute of Human Genetics and the Cancer Center. But there continued to be major financial and hospital-related problems.

Before and after I became dean in 1996, there were evolutionary changes in the healthcare programs nationally, development of HMOs, especially at Minnesota. We were far and away ahead of everybody in the nation in healthcare reform at that time.

Certainly during my tenure as dean, the finances were open and there was direct involvement with private practice. Probably during the latter part of David Brown's career, he had more of a role in that; although, there was always this feeling among the

older leaders that they didn't want the dean involved in this stuff. [chuckles] It influenced who would become dean, actually. That changed.

I think the reason it changed is not simply because of an awakening of a faculty. It came about largely because of the cataclysmic change in healthcare that started in the 1990s, even late 1980s, with the development of HMOs and hospital organizations. That forced the issue. The formation of University of Minnesota physicians in the 1990s was a major component of reform.

DT: When I interviewed Bob Howard, he mentioned that he'd been asked by, I think, two different presidents to try and take on the private practice issue, and he tried and, then, faced that strong resistance from those individuals in Surgery and Psychiatry that you mention.

AM: Yes.

DT: He hadn't been able to do it. But that had tarnished his tenure.

AM: Yes. That was a hard, impossible job when you really get down to it, regardless of whatever talents he had for it. It was a bitter pill. I know he wrote an article—I can't remember when, a number of years later—about what had happened that was bitter. It was a tragedy in my view. [sigh]

At any rate, that's what evolved.

Let's see. In the early 1990s, I was head of the Department of Pediatrics at the time and was involved with a group chaired by Win Wallin. Wallin had been brought over by the president [Nils Hasselmo] to be a *vice president* without a salary. It occurred at a time after the Najarian affair. The members of the group also included Shelley Chou [acting vice president and dean], Richard Elzay [dean of the School of Dentistry], Greg Hart [hospital administrator], and others. The goal was to redesign how things should be handled. There were a lot of frailties in the system. We had a hospital director that reported to the president and we had a dean who, at that time, reported to the vice president and the president. This was a long story. Win Wallin was remarkable. Of all the outstanding people that I've known at the University, Win Wallin was among the top. He had a real facility for listening to people and working things out. Essentially, that committee put together what we thought was a good structure, which was based upon a single leader for both the Hospital, and the Medical School, and for the entire health sciences.

I led the large search committee for that recruitment. Win Wallin was also on the committee, actually. Bill [William] Brody was selected as the provost of the health system. Of course, he was only there for a year and a half, and, then, went back to be president of [Johns] Hopkins, where he came from. He was a radiologist, Ph.D., electrical engineer, a very talented guy. He got into a lot of difficulties with threats of getting rid of tenure—that erupted *nationally*. Some people on the Board of Regents

were very upset at the time of the Najarian affair. That led to Dave Brown having to give up the deanship. There was still a lot of healing to be done.

Of course, there was still the University Hospital, at that time, which wasn't sold to Fairview until after Bill Brody had been recruited. There was the possibility of either going with Allina or of going with Fairview, but ended up being sold to Fairview, which I think was the right decision, actually.

There were perceptions of a dichotomy between the south of Washington Avenue and the north of Washington Avenue, the health sciences versus the rest of the University. Health sciences, big, a lot of money from the NIH. The rest of the University thought, what's going on over there? Of course, the time that led up to this, in part, was the Najarian affair and that was very, very troublesome. The *Minneapolis Star Tribune* had a whole succession of articles over a period of time hitting the Medical School. It was a *very* hard time, and David Brown was dean at that time. The Regents were upset and led to David having to leave the deanship. He was inappropriately blamed for things, in my view. Generally, Dave tried to do a very good job and was in a very difficult position, at that time.

Have you interviewed David?

DT: I've been trying to get a hold of him.

AM: You should interview David.

DT: Yes, I want to.

AM: Then, you can get it from his perspective.

This era, which I think started in the early 1990s up until the founding of the Academic Health Center [AHC], essentially, with the recruitment of Bill Brody as a single leader, was a critical era within the University.

DT: I have David Brown's phone number, so I'm going to try and call him next week, because I travel tomorrow.

It's interesting that you talk about the reconfiguration of, basically, the position of the senior vice president into provost, that Brody was to be in charge of absolutely everything in the health sciences.

AM: Yes.

DT: My understanding had been that in 1970, when Lyle French was appointed as senior vice president, that had been the goal then: to have that senior vice president position be in charge of Hospital, Medicine, Nursing, Dentistry, Public Health. Does that suggest that something had failed with the earlier model, and what was that?

AM: Lyle's organization was small and nonintrusive—nothing of the magnitude of the current AHC. It was run out of a small office with Cherie Perlmutter... Have you talked to Cherie?

DT: She's on my list, too.

AM: Cherie is critical for you to talk to. When I was dean, I brought her into the dean's office. Cherie had worked for Lyle French, so she knows what went on there. She's a critical person in all of this. After Lyle left, Bob Anderson and then Neal Vanselow came in. Cherie became v.p., and after he left, ran the office herself, during that period.

Bob Anderson was v.p. at the time we suffered through the problems in surgery, the litigation against John Najarian, and the continual adverse newspaper coverage. The physicians, at the time, weren't in any other clinical organization. Departments had their own practices. He and I tried to bring it together, and I respect him immensely. Was he upset about the fact that the dean didn't know everything? I don't know, as I sit back and think about that. He was part of the leadership of the school, but, then, that's the way it was. I know Shelley, later on, was very supportive of the essential changes. Even though Lyle French was senior vice president for health sciences, the evolution in healthcare delivery was in its very early stages. This revolution was a prime factor in the necessary restructuring that followed as developed by the Wallin committee.

DT: Yes.

AM: When Bill Brody decided to leave, Frank Cerra took over the leadership, and the Academic Health Center was really in full swing.

DT: I appreciate you talking about the fact that the medical faculty had so many different group practices or practices within the school. How did that change when the University of Minnesota Clinical Associates [UMPCA] was established in 1985? As I understand it, that was kind of the centralizing of faculty.

AM: It started, but it really didn't get going well until the 1990s and *finally* with the development of University of Minnesota Physicians [UMP]. That was done because there was no effective clinical system that could operate in the healthcare marketplace. So it brought everybody into the practice. The Hospital was sitting over here, having trouble making ends meet. The system was screwed up.

Actually, as I look back, a lot of work has been done in the last twenty to twenty-five years to get things straightened out. The University of Minnesota Physicians became an outstanding organization. I think the connection with the Fairview is generally a very good connection. People still argue, "Did we really have to sell the Hospital to Fairview?" There are faculty members who oppose that and think that was the wrong decision. Could you have gone another way? I don't think so. There was not the money

or the organization in the system to do it, to have it happen at that time. And the Twin City competition was a major stumbling block.

DT: This kind of recrafting of the health sciences in the committee that Win Wallin led occurred after the University of Minnesota Physicians was formed and became part of the University of Minnesota health system?

AM: The health system as formed initially included the health science schools, the practice plans, and the Hospital under one leadership. I don't think Brody had enough time but under his leadership. The University Hospital was sold to Fairview Health Systems. There was anger about us becoming part of Fairview. What are we giving up? A *myriad* of problems that have taken years to work out. It's like the current health system with Obama Care. It will take years to get it straightened out, really. We were not adequately positioned to compete in the current marketplace.

The Academic Health Center now came about...

[break in the interview]

AM: ...to unify health programs at the University. But in many places in the nation, an academic health center includes the hospital. The core is the medical school and the hospital, usually. The University of Minnesota had no hospital. It was sold. For this reason, there's always been some argument about how big the Academic Health Center should be...

[break in the interview]

AM: The value of the Academic Health Center is that it allowed schools and programs to interact and to come together to foster research and education. In addition, it joined health science schools together administratively. I have several concerns. First is that the development of new programs in the AHC would be competitive with existing programs that logically belong in the Medical School. In a number of circumstances, this occurred.

When I became the dean in 1996, the president of the University had just been appointed, Mark Yudof. I remember I had conversations with him, and he would talk about structures being flat. I remember saying to him, "Well, then, I hope that we keep the super structures above the medical school flat and that individual schools and leadership be responsible for themselves." In this sense, programs within the Academic Health Center would include programs that can't be orchestrated within the individual school.

I think some administrative programs are important. How do you deal with, say, some of the aggregate issues? It's not useful to have each school have its own specific leadership for email services or electronic services, et cetera. There are certain things, one could argue, that are part of baseline programs that could be more efficiently managed across the breadth of the Academic Health Center. They would save money and be efficient.

In my view, academic programs—education and research—and clinical practice should reside in the school. Resources should go down to where the action is. The action of the school is its educational research mission and in the Medical School, also the clinical mission.

One could argue, “How about the connection *between* the schools? Do you need an academic health center for connection between the schools?” My view of that would be that you don’t. The schools are smart enough, bright enough that deans would sit down and talk together and connect whenever it was necessary to connect. You don’t need another structure to try to work out the connections.

DT: So that’s what you mean by kind of potentially competitive units within the AHC?

AM: That’s caused some confusion among the deans, certainly in the Medical School. I think if you’d talk to prior deans or myself about that, we’re very concerned that competitive units influence innovation in the Medical School. If you’re going to have a dean, you should have a dean who’s a dean who is going to succeed. If not, get somebody else who can do it. It’s hard to answer this with superstructures. I’m not saying it shouldn’t exist, because I think there are certain platform issues in which you need things for certain commonality issues for governance of the various schools.

DT: What about for research centers that are doing interdisciplinary work within the health sciences? Is there a place for them to be in the Academic Health Center?

AM: I think it depends on the program. For example, if I could give an illustration of global health, where that’s of value, from the point of international relations and travel and the development of research, educational programs for all health science schools.

There’s always been somewhat of a feeling in the Medical School, a concern among the faculty about things being pulled out from the school.

The administrative structure should support the creativity of the faculty and the education of the students within the schools. Creativity and imagination come from individuals and come from relatively small structures, where the action is. It’s bottom up and not top down.

DT: What’s your position then on the fact that now the vice president for health sciences is also the dean of the Medical School?

AM: I think that’s appropriate, actually. I have one worry about it, and that is there’s going to be a limited amount of hours in the day. So it’s going to take recruiting somebody who is a very effective person. That would mean if you build a structure that is heavy within the Academic Health Center, and you have the Medical School, it may be very difficult to manage both. The crucial position is training doctors and health professionals, taking care of sick people, and doing science. That’s the critical thing. That’s in the Medical School. The dean should be there.

It makes sense that the dean of the Medical School be the vice president, but, then, the platter of the vice president needs to be very critically looked at. The president needs one person to talk to the v.p. about health generally. If there's an issue about health, that would be one role for this dean/v.p. to report to the president for overall management. It consolidates it and inhibits competitive structures.

Having the dean of the health science schools responsible for everything that goes on in their schools and limiting the development of overlapping programs in the AHC simplifies the administrative structure.

What I'd like to see happen is make the schools and deans responsible for various programs and set the stage that individual deans can connect over existing programs or programs in which they have commonality. You're rarely going to have all the schools that have the same programs. Limit what's in the Academic Health Center to those ingredients that are uniform across the schools, information technology, global health, and administrative and financial programs.

That's my view about what I'd like to see happen to the Academic Health Center.

DT: In reference to the other health science schools during your time at the University, how do you think relations between the Medical School and Nursing School, say, for example, have changed over that time?

AM: Nursing. First of all, there are certainly individual faculty connections and joint appointments between the Medical School and the Nursing School, such as pediatrics. I'm not sure, however, that there's been any real in-depth connections. It's been more on an individual faculty basis. When I was dean, I don't recall any in-depth co-development of major programs, just smaller programs. In retrospect, I believe we need more interactions among faculty.

DT: Is that largely the same for the other schools, as well, with Public Health, Dentistry, Pharmacy, these individual faculty connections?

AM: Yes, I think... For example, I established the International Health Program in the Medical School. We, several years later, invited the School of Public Health to join us in that endeavor. That was before the global health initiative got going. There have been numerous research activities between faculty in the School of Public Health and the Medical School.

DT: You have more confidence that if there is a collaboration to be had or coordination to be had, the deans will take that initiative and do it. They don't need to be told what to do.

AM: Yes. I think they'll do it if it's critical for the school. I think the deans will work together on issues. I think they always have. They don't need somebody telling them

what to do. I think innovation comes, as I mentioned before, usually from bottom up anyway. It's smart people thinking about how to do things.

DT: Your description of John Anderson earlier and about his leadership of the Pediatric Department... In a way, it was a hands-off approach but that, at least, fostered innovation among the faculty.

AM: Right. He supported it, and he allowed it to occur. There's always a danger that a strong leader who calls all the shots can stifle individual initiative and creativity rather than fostering it.

DT: You mentioned a few times now the Najarian affair. I wonder if you could give your perspective on what happened with the ALG [Antilymphocyte Globulin] situation.

AM: Yes. It occurred at a bad time. It occurred during the time of the shakeup of the healthcare system. I was concerned about what was happening since I had worked closely with John Najarian. I think he was a great surgeon and a good scientist. His activities were largely concerned with transplantation. He developed a powerhouse in transplantation biology at the University and got a lot of credit for his achievements.

It's funny how things happen. You do things... I think back on my own career. Some of the things I did with respect to using drugs and so forth to the best of my ability and knowledge, if it were looked at in today's light, one might say, "Boy, that was questionable. Was that really right?" I was doing it because I thought it was the best thing I could do for the patient. That, to me, is the thing that I stand on, and I'm not going to worry about that. Things I did as a physician in the military, I wouldn't even want to tell people about. In order to get things done to take care of soldiers, you flouted rules.

I think John didn't dot every i and necessarily follow every single rule with respect to ALG. They were making it. Dick [Richard] Condie was running the program. But this was an advanced program. They were trying to solve problems and take care of sick transplant patients. The investigators got in and looked around to find things that didn't appear appropriate. Well, the judge, appropriately, threw it out of court is what happened. I know John took a major hit on this after doing an outstanding job with respect to transplantation in the Medical School. I don't know enough specifically about which rules didn't apply to him. As I see myself in the past, I was often trying to get something done, do it, and damn the torpedoes. Full speed ahead. So there may have been an element of that. It certainly wasn't of a magnitude to bring a criminal investigation against John Najarian at all. I think that was a travesty, in retrospect. Now, I know a lot of people in the institution were upset about that. They thought it brought bad light on the University, and it did. But I think the judge saw it pretty clearly. He just threw it out of court. It hurt the institution and gave us a lot of very bad press. They began snooping around for anything they could find out. If you snoop enough, you'll find somebody that's made mistakes. It was a horrible time for the Medical School in the 1990s.

In part, that's what happened with Dave Brown.

DT: Several people, including John Najarian, certainly in the book he wrote and even when I interviewed him, too...the contention was that the people in the dean's office, in the vice president's office, the president's office, and at the NIH and the FDA knew what was going on, knew what was happening.

AM: Yes.

DT: What's your take on that?

AM: I can look back at that time, but I wasn't too involved in it. I suspect that... Was there enough supervision of what was going on is the question, enough responsibility of the institution? Probably not. Many institutions in the U.S. have had somewhat similar accusations from the government that involved research and patient care. Remember this was a time of major changes in healthcare. Well, today, there's a lot of supervision and rigid accountability. Everything is tight.

Your question...should the institution have had enough safeguards that this shouldn't have happened? In retrospect, yes. Sure it should have, but it didn't.

DT: Why do you think the University took criminal action against Najarian?

AM: I didn't know what was going on at the time. I think Shelley Chou was involved in that rather heavily, as I recall.

This was the early 1990s, wasn't it?

DT: Yes.

AM: I don't know if I can answer your question, because I don't know enough specifics about what was going on at that time. I was heavily involved in research and was running Pediatrics. I knew generally what was going on but not the specifics. I didn't get too much involved in what was going on with that. It was distressing to everybody. I don't know what the role of the University was and who was calling the shots. I imagine it was Nils Hasselmo that was doing it. It was under his leadership, at any rate.

[pause]

AM: My own career... I maintained a good research career even after I became head of Pediatrics. Roughly until the early 1990s, I was still doing a lot of research and chairing pediatrics until I became dean. Then, I didn't have time to do anything.

DT: [chuckles]

Given how much research you were doing and how much clinical work you were doing, did you have a lot of teaching responsibilities, too?

AM: Oh, yes. We always had fellows and residents and students. I'd give lectures on the kidney. It was a lot of rounding, having fellows and students and residents with you, that kind of teaching. But I became more administrative. I had decided I didn't want to be a department chairman. I had a lot of offers around the country to do that. I turned them all down. Then, I turned down Minnesota and, then, finally they got me. The same thing happened with the deanship. I kept pushing it off, because I always thought the most important thing in life was taking care of sick people and trying to do science and teach. That is true. Once you become an administrator, you're not doing those things directly. You're trying to form the infrastructure for it. You're trying to foment it, get it going, support it. So indirectly, you're involved in it.

DT: I've always imagined for someone like yourself, that you're so fully engaged with research and have such an important research role in such an important research program that it would be a hard decision to go into administration.

AM: It's hard.

DT: How do you balance that?

AM: I was still an NIH merit awardee while I was head of the Department of Pediatrics. So I was heavily research granted during those years. That took a lot of time. Once you become dean, you have responsibilities for the institution and the faculty. I was working...I would tell Jeanne [Doctor Michael's wife, Jeanne Jones]... We'd get up in the morning and I'd be there at seven. I'd get home by seven-thirty. Some nights I was out at some party or something that I had to do something with. Six years was enough of that. [laughter]

It's been a great run, however. I think back on how lucky I was to have the career that I've had. I wouldn't have wanted to do anything else, but this. Then, when you leave—I retired five years ago at the age of seventy-eight—there's a great life after you leave. I've never had the sense after leaving the University, oh, I wish I was back. No, I don't have that at all.

There's other things I'm doing. I'm on the Board of Saint Mary's Health Clinic here in town, which is the Sisters of Saint Joseph of Carondelet. They are concerned with largely undocumented immigrants who have no options for healthcare and no insurance, can't get even Medicaid. And I'm involved with a group that just finished a clinic in Port Salut, Haiti, that deals with children. It's a major children's clinic for one of the poorest parts of the world. I'm happy with that. And I'm still on the Viking Children's Fund Board. I started the Viking Children's Fund here twenty-seven, twenty-eight years ago. I keep telling them, "I shouldn't even be coming to this anymore."

DT: It sounds like it.

AM: I don't have any desire to... I go to the U mainly because I'm involved in the Pediatric Total Health Program. We've connected the program in Haiti for the children's clinic with the University Medical School and the Academic Health Center. So I've been very involved in getting that connection. The clinic is going to be done soon, and it will be a site for residents and students and so forth, and other physicians. That's what I've been giving my energy to, actually.

DT: That sounds great.

AM: It's another facet in life.

DT: During your time at the Medical School, particularly when you were dean, how were relations with the State Legislature? As dean, did you have to go before the Legislature?

AM: Yes, many times. Frank and I'd be over there, or I'd be over there by myself. Yes, it was sort of interesting.

In fact, I've even been over there since then, mainly when [Tim] Pawlenty was governor. I was concerned about healthcare for the poor in Minnesota and what they were going to do to the two-percent tax. That's a tax on all physicians, psychologists, anybody who practices. It was levied here years ago as money to support healthcare for the poor. There was a movement out of the Pawlenty Administration to take that money and put it in the general fund. So a lot of us really opposed that vigorously, so I'd been over at the Legislature talking on that with the legislators. I'm doing less of that now—not that I'm not interested. I'm waiting to see what the Supreme Court decides about healthcare in the United States...

DT: Yes, aren't we all?

AM: ...by the end of June. That's another avenue that I have been really very, very interested in. I believe that the basic ill of society is poverty, so I try to give my energy to that and part of that is dealing with healthcare in Haiti. It's all connected with poverty.

DT: It makes me think about the comment you made earlier about the Catholic bishops and, of course, the recent controversy they've had singling out the nuns as being too feminist or...

AM: Oh, that is ridiculous.

DT: Then, of course, the nuns are the ones on the ground fulfilling the social justice mission.

AM: Absolutely. Can you imagine? The bishops thought that the sisters were giving too much emphasis to healthcare and the poor and not enough on opposing homosexual marriage.

DT: It doesn't show them in any good light whatsoever. I'm not Catholic, but I went to a Catholic high school. There was convent there, so I've always had a warm feeling for nuns, but just the juxtaposition of what the nuns are doing and what the bishops are saying is troubling.

AM: I go over there frequently to the Sisters of Saint Joseph because I'm on their health board and their foundation board.

When will you be completing this work?

DT: I've got another eighteen months to maybe two years.

AM: Oh, wow.

DT: So far, I've interviewed a good number of people from Public Health, Nursing, Medicine, and a few from Veterinary Medicine, and some of the Hospital directors, too. This summer, I'm going to start talking to the College of Pharmacy and will have to, in the next year, hit the Dental School, too. There are, still, many people from Nursing that I need to speak with and the other schools, too. It's a process that's ongoing.

AM: Have you talked to Sandy [Sandra] Edwardson?

DT: She's actually one of the people that I'd love to talk to.

AM: She'd be good to talk to. She's very level.

Actually look at the schools, and they are good schools. Pharmacy, I think is second nationally in the last rating I had. So Minnesota does a good job. It's always concerned about financial support, et cetera. The institution always needs more money, no question about it. In general, the quality of the schools is good. We always had a problem in the Medical School in that if you look at the ratings of medical schools, we were, I'd say, about tenth in the nation for a number of years, and, then, started down about twenty years ago. I have a graph of this actually.

DT: Yes, I think thirty-five.

AM: One can logically inquire, "Why did it come down?" If you look back, I don't know where the inflection was, but I think it was something like twenty years ago, roughly, it was probably resource derived. You're never sure why. Part of it was it was an investment in primary care from the state, which wanted to develop a primary care program. You look at that, and, if you were at a private school, you wouldn't necessarily invest the money in that. But we're a state school, and we should invest money in

primary care, because we should be making family practitioners. It's just that the amount of money available...and if you look at the numbers, the investment, say, in the University has gone like this per capita; whereas, the investment in social services and healthcare has gone like this. They're mirror images of each other. Well, forty years ago, they weren't investing in all these other ancillary things. The state has a limited amount of money. That's reality. We have one of the biggest medical schools in the country right now, as far as the number of graduates that come out. I think the educational program has done pretty well at the U. I'm proud of that over the years. I think the quality of the practitioners has been good. We'd all like to see more money come in, NIH resources. These are tough times to do that. It's hard to compete the private schools, because they can narrow their programs. They're not confronted with the idea that we had to increase our number of students in order to meet the healthcare needs. You can be Harvard and just train 120 students. That's it. We double that. We're really not far from our mission. What's our role as a state institution? Although as dean you would like to see us in the top ten in the nation and not in the top thirty-five in nation. That's life. There's nothing you can do about that.

When I was dean, I spent most of my time reorganizing the Medical School and bringing more participation in from the faculty. We developed councils, an educational council and a research council, and really built up the faculty council from the point of view of elected members that had a role in governance. I had a number of important retreats for the whole school dealing with research and the vision and aims of the school, et cetera. It was all very healthy. What happens is, I did that, then another dean is going to do something similar to that, maybe a little different phase, a little different approach. We do those things in order to keep vitality up and keep it going.

I'm comfortable with where the school is, actually. I'd like to see more resources go into it, but I know that's a problem right now for the whole University.

I was sorry to hear about issues raised about Bob Bruiniks in the newspapers. He's such a wonderful guy. Do you know Bob?

DT: I've never met him, no.

AM: He's a good guy, a good person.

How's Frank doing? Do you see him?

DT: I saw him about two weeks ago. He's always relaxed, much more relaxed. He's dressed in jeans and a shirt, no tie, so he looks far more relaxed

AM: Is his office over in Surgery?

DT: Yes, and there's barely anything in it. [chuckles] It's sparsely populated. He seems well.

AM: What's he doing now?

DT: He's looking into the history. He wants to write a book of Minnesota's Academic Health Center. He's doing a lot of reading in the Archives, reading my interviews. I think he's still doing meetings and what not. He looks well.

AM: That's good. He's probably one of the hardest working physicians I've known. I guess I knew him best in the Academic Health Center, but he put in the energy, worked very, very hard. He did a good job, though he and I had different views regarding the AHC.

I thought, God, he would have been a good lawyer. The issues related to compliance and concern about governmental rules and regulation. Are you doing the job right, et cetera? He handled it pretty well.

DT: This has been fantastic.

AM: All right.

DT: I'm out of questions. This has been great.

AM: Thank you very much for coming by. I do appreciate it.

DT: Thank you.

[End of the interview]

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