

**Robert McCollister, MD**

Narrator

**Dominique A. Tobbell, Ph.D.**

Interviewer

**ACADEMIC HEALTH CENTER  
ORAL HISTORY PROJECT**

**UNIVERSITY OF MINNESOTA**

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

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

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 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**

Robert McCollister was born in Iowa City, Iowa, on July 27, 1828. He received his MD degree from the University of Iowa in 1953. He did his internship in Oakland, California. After medical school, he served as a flight surgeon in the US Air force from 1953 to 1955. He completed his residency training in internal medicine at the Veterans Administration Hospital in Minneapolis (1955-58) and then in the Department of Laboratory Medicine the University of Minnesota, doing research with Dr. Ellis Benson (1958-59). In 1960, he was chief resident in medicine at the University Hospital and was appointed instructor in the Department of Medicine. From 1961-62, he did research at Duke University in hematology in the Research Training Program. In 1962, he returned to the University of Minnesota to take up a faculty position in the Division of Hematology within the Department of Medicine. In 1964, he was appointed as a part-time assistant dean of student affairs in the College of Medical Sciences. In the late 1960s he joined the dean's office in support of the Educational Policy Committee, an initiative to examine and refine the Medical School's curriculum. In the early 1980s, Dr. McCollister was appointed associate dean of curriculum affairs in the medical school. He retired in 2005.

## **Interview Abstract**

Robert McCollister begins by discussing his background, including his education and medical training. He discusses getting into administration, how he became involved with the curriculum, working in the Department of Laboratory Medicine, and his work as assistant dean of student affairs. He offers many reflections on the development of the Medical School curriculum. He describes the work to improve the governance in the Medical School in the mid-1960s, revising the curriculum in the 1960s, the expansion of Medical School class size in the 1960s, recruitment of minority students, and Robert Howard's departure as dean of the College of Medical Sciences and the appointment of Lyle French as the first Vice President of the Health Sciences. He discusses the Educational Policy Committee, the large number of women in leadership positions in the Department of Laboratory Medicine, the reorganization of the health sciences in 1970, department "fiefdoms", Curriculum 2010, the Comprehensive Clinic, the Department of Family and Community Health, specialization in medicine, Phase C of the medical school curriculum, the teaching of behavioral science within the curriculum, transfer students from the Dakotas, the Program in Human Sexuality, and the student attempt to get a medical ethics course included in the curriculum. He talks about Ray Amberg, C.J. Watson, Richard Ebert, Frederic Kottke, Robert Howard, Benjamin Fuller, Frank Cerra, and Lyle French.

**Interview with Robert McCollister**

**Interviewed by Dominique Tobbell, Oral Historian**

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

**Interviewed on December 9, 2009**

Robert McCollister - RM

Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Bob McCollister. It is December 9, 2009, and we're in Doctor McCollister's office, which is D-699 in the Mayo Building [University of Minnesota Campus].

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

RM: Sure.

DT: I have a series of things I'd love to talk to you about. First off, I'd like to get some background on where you were born and where you did your medical studies, for example.

RM: All right, and, perhaps, how I got into administration.

DT: Yes.

RM: I'm a graduate of the University of Iowa School of Medicine, and I did my internship at a county hospital in Oakland, California, which was very common in those days. There were a large number of California county hospitals that young graduates would go out from the Midwest and get a year's experience. Then, I went into the Air Force and, then, applied for residency in internal medicine at a number of places. Minnesota was a place that I wanted to come. I was assigned first to the V.A. [Veterans Administration] Hospital [Minneapolis, Minnesota]. In fact, I did all of my residency training at the V.A. in the Department of Medicine, which was, then, headed by Doctor Cecil [C.J.] Watson.

I could comment about a lot of things about the residency. In those days, the talk was that it [the V.A. Hospital] was probably one of the better places to do a residency, here in the Department of Medicine, because all of the bright, young or middle-aged people who aspired to leadership took advantage of that opportunity to move out to the V.A. and have their own thing away from the presence of Doctor Watson, who was a dominating figure

at Minnesota. I think it was difficult for young people to make their own way in the shadow of such a powerful head of the department. So, in those days, we were taught by Paul Hagen in Hematology and Les [Leslie] Zieve in, essentially it turned out to be, Endocrine. There was Wendell Hall and Horace Zimmerman both in Infectious Disease. The head out there was Ed [Edmund] Flink, who was one of the premier graduates of the Medical School and was selected by Doctor Watson to be head of Medicine. I didn't know all of this before I came, but, in the end, it turned out to be a very good place to train in internal medicine. During part of it, I was really under Doctor Flink. In a sense, I was in a way his protégé. I was interested in chemistry. I'd written a paper out there. They came around to residents and said, "Now, it's your turn to write a paper for grand rounds." I wrote a paper on melanin metabolism that got published in *Minnesota Medicine*. In fact, I did research my first year at the V.A. [Veterans Administration] Hospital under Doctor Flink on magnesium metabolism. So my training was in internal medicine, but it certainly had an academic tilt to what I was trying to do. I did research and some of it got published. At a certain point, Doctor Flink arranged for me to spend a year in the Department of Laboratory Medicine. In those days, Doctor Gerald Evans was head of Lab Medicine. Doctor Ellis Benson was his right hand person. This was 1959. Well, the Mayo Building was built in 1958, so that was a brand new building. So I did a year of research.

I was appointed to be chief resident and was that for a year, and, then, did research and was a member of the Department of Medicine staff and Endocrinology, really, which is what I had been interested in. You have to realize that in those days, there was not subspecialty training in internal medicine. People followed their general interests. In any event, it's so different now, much more structured now. At a certain point, I was involved in Endocrinology.

After I was in the Department of Medicine for a year or two, I got an appointment at Duke University for a year to be in what was called a Research Training Program. It was put together by Doctor [James] Jim Wyngaarden, who was one of the large figures in American medicine. He was a big shot. He put together what was called a Research Training Program at Duke. There was a national need for more clinical investigators. The idea was all of the science was bubbling around and there weren't enough people to do research, so they put a training program together, and many doctors, like myself, that had gone through residency and really hadn't had formal training in research were put through this one-year program.

Then I left Duke. I could have stayed on, but I came back because Doctor Watson offered me a position in Hematology, because I had done research in a subject [purine metabolism] that was, in a way, akin to hematology. I had no special training in hematology. So, suddenly, I'm in Hematology. But it turned out I became really interested in that area. In those days, endocrinology was the business of, essentially, to make a diagnosis of someone with thyroid disease or some strange adrenal problem. You diagnose it and they get treatment, and that's it. Okay. It isn't quite true because diabetes is one of the endocrine problems and that needs long-term care. But diabetes wasn't a big part of endocrine in those days. Hematology, on the other hand, was the

kind of disease where you not only made diagnoses but you had to go ahead manage the patient. Anyway, that attracted me.

In any event, I was in the Department of Medicine. In those days, one of the big things was the legislature—it still is, but it was even bigger in those days. The legislators in Saint Paul all thought that the Medical School was the University Hospital. That's what they thought. It wasn't. The, then, director of the University Hospital, Ray Amberg,], a large, gentle, rather pleasant man who kind of rolled along would go over every year to the legislature and spend a lot of time there glad handing the legislators and getting money for the University Hospital. In doing so, he would say to the legislators—they'd be coming from Thief River Falls, or other outstate area—"Have you had a check up lately?" "Well, no, I haven't, Ray." "Well, you know we've got good doctors over there at the Medical School." Thereby, he was representing the Medical School. What would happen would be Ray Amberg got the legislators free physical exams over at the hospital. The person that did those initially was N. L. [Neal] Gault, and I was also doing them then, because I was a young internist then, and I love to do physical exams, and I did very complete exams. So I must have seen dozens and dozens of legislators, and so did Neal Gault. Neal got to know me a little bit.

One day, after I'd come back from Duke, I was having trouble with my research anyway, like everybody does, he says, "They're looking for somebody in the dean's office"—at that time, he was assistant dean—"to help out in Student Affairs. Would you be interested?" I thought that sounded really interesting. So after coming to Minnesota in 1955, eight or nine years later, I was appointed to be assistant dean in Student Affairs under Mead Cavert. He was the senior person in Student Affairs and I was his assistant in those days.

It's often who you know, and I happened to know the right person. In these days, they would have to have a search for them. I don't know that I was even interviewed by the, then, dean, Bob Howard. Anyway, that was how I got into the deanery. I was there from 1964 to whenever I retired, which was, officially I guess, 1997. Greg [Gregory M.] Vercellotti took over the curriculum from me.

That was a long story, I'm afraid.

DT: No, that's exactly the kind that I'm looking for. That's great.

Would you mind if I close that door to shut out some of the noise?

RM: Yes, that's fine.

About getting into the Medical School, I made a few notes about that in kind of a global way that I thought might help you. The reason I got into curriculum... You might say, "Well, how did you get from that point...?" I was doing Student Affairs in those days, Mead and I both. In those days, the drill was we'd split the classes, so for one entering

class, I'd be the assistant Student Affairs dean, and the other Mead would be. So that happened for a couple, three years.

About that time, part of that was doing dean's letters of recommendation. I got to the point in the late 1960s when I was doing *all* of the dean's letters for the entire graduating class, because Mead got busy being the dean pro tem of the Medical School. I remember for two or three years, I did all of the dean's letters for 200 and some graduates, which was a monumental task. I remember taking the dean's letter folders home one Thanksgiving and writing those up.

I got involved in curriculum because, in the mid 1960s... That will be another whole chapter, I imagine.

In the mid 1960s, there was an impetus to improve governance in the Medical School, and the governance was done by having a constitution of the Medical School created. I think that was probably stimulated by Central Administration. They said, "You have this big unit over there and you don't even have a constitution." So they did a constitution and they established some standing committees. One of them was an Educational Policy Committee. Another was an Admissions Committee. Another was a Committee—I remember everybody laughed—on Committees, which was to recommend faculty for vacancies on the standing committees. That was Wallace Armstrong's, I think, contribution to the constitution for the Committee on Committees.

Anyway, they established an Educational Policy Committee and because the constitution then gave a framework, the faculty set about in earnest under the leadership of Dick [Richard] Ebert, who was appointed the first chairman, to take a hard look at the Medical School curriculum. As assistant dean and involved in Student Affairs, I somehow got a staffing job with that, so I was the dean's office rep [representative] on the EPC, Educational Policy Committee, which started in the late 1960s. It does go on now and it's got a different name. There has been that continuity. I have dredged out the annual reports of the EPC. In fact, I just saw Ted [Theodore] Thompson and asked him, "What's going on, Ted? I'm out of the loop." Ted said, "There aren't any loops anymore. That's one of the problems." I said, "How is the faculty keeping apprised of what's going on in the curriculum because there's all this stirring around?" Well, it's not like it used to be. I sense people do not hear what's going on. In fact, I saw Scott Davenport down the hall. He said, "We hear rumors all the time how things are going to change in the curriculum. Nobody is telling us what's going...." Oh, well, okay. So that's modern day.

Anyway, that's how I got into curriculum was that I happened to be in the dean's office. There was a new impetus for looking seriously at education. Dick Ebert was the spark plug in that, and I was right there, and I ended up being Dick Ebert's right hand person implementing the curriculum change, which, in fact, more or less, persists to this day. I can tell you what's changed, but the basic framework of the curriculum that was established in 1969 is still extant and hasn't changed very much. Concern by the basic scientists and others that the new revisions are going in the wrong direction.

Nonetheless, I've had nothing to do with what's going on, but I know that the framework which is truncated basic science courses in year one, a pathophysiology segment in year two, and mandatory clerkships in year three and four. That's still the curriculum in the school.

So that's that background.

DT: I have a few follow up questions, and, then, we can keep on moving.

RM: Go ahead.

DT: First of all, you kind of mentioned what it was like being in the department with Doctor Watson as head. Do you have anything else you can elaborate on what it was like working under Doctor Watson?

RM: Well, when I was chief resident, of course, I made rounds with Doctor Watson three times a week. The chief's rounds were held three mornings each week; patients would go on and so things would be presented, and the chief resident would have to be sure that all the players were in line. How I pulled this off, God, I don't know.

[chuckles]

RM: I wish I had made notes of the cases we had seen. I wish I had made notes of many things that Doctor Watson said. My successor, Dick Davis, who was the assistant to the chief resident you might say—he was the Heart Hospital chief resident under me—did do so, when he became chief resident the following year. He did make notes, and I think he published a paper on aphorisms, some things C.J. Watson had said, something like had been done with other famous physicians that people that have followed, like [William] Osler or Eugene Stead at Duke. Doctor Watson was a very highly respected individual, very precise, very gentlemanly, a courtly individual, extremely knowledgeable, very taken with his background that he had spent... He worked under the great Hans Fischer, who was a great chemist in Germany, when he was a young man. That's where he studied the porphyrins and became expert at crystallizing porphyrins. Han Fischer was a great inorganic chemist. So he [Doctor Watson] remembered all those German times. I remember that he was very taken by that.

He retired shortly after that; he retired in 1966. I remember being at an administrative board meeting where he announced that. I remember Owen Wangenstein coming up to him. Owen was a smaller man. He said [Doctor McCollister speaks in a high-pitched voice], "Oh, Cecil. You really surprise me. Are you really going to retire?"

When Doctor Watson went over to Abbott Northwestern [Hospital], he, in a way, took kind of a coterie of individuals over there and established the residency, which persists to this day. It's a very popular internal medicine residency.

So I can't say too much about Doctor Watson, and the Department of Medicine times.



Under Doctor Ebert's leadership, that was a time of growth in the Department of Medicine. Ebert came here. There were two famous Ebert brothers from Chicago. His brother, Robert Ebert... I'll tell you a little story. One time, I went to Doctor [Richard] Ebert's office, and he was just on the phone. He was always popping into one's office. We had offices on the thirteenth floor. He would often just pop into your office. You never could tell when he was going to pop in. One day he was on the phone. He turned to me and he says, "Why do all deans have to be named Robert?" [laughter] He looks at me. I didn't know. At that time in the dean's office, we had Robert Ulstrom. We had Robert B. Howard. We had Robert Mulhausen. We had Robert McCollister, and his [Doctor Ebert's] brother was named Robert. Robert Ebert became dean at Harvard. He was very famous. He put together the Harvard Community Health Plan, among other things. He was very well respected. Those were the two Ebert brothers. Dick Ebert was at Arkansas where he was head of medicine before he came here to Minnesota. He was appointed the head of the department, or chosen to be head of the department after Doctor Watson and had a lot of connections in Chicago. A lot of people at the V.A. research hospital in Chicago knew Dick Ebert, including Craig Borden. There was a group of young academic internists in those days, and he was part of that coterie. The head of medicine at Indiana—I've forgotten his name—was another one of those people where people [in academic internal medicine] knew each other.

Ebert was a good builder. He built the department. If you look at the department in the 1970s, he made some very, very key appointments in the department. Doctor Watson had appointed Harry [S.] Jacob in Hematology I think before he retired, but the appointments that Ebert made... Jack Oppenheimer in Endocrinology, and he got Howard Burchell up from the Mayo Clinic [Rochester, Minnesota] to head Cardiology. Ebert was a world-class appointment way beyond his time, in a sense, but he was the right person who could attract other people like Jay Cohn. He appointed Dodd Wilson in Gastroenterology. There were just all kinds of people that he got, so he built the department. I don't think he's been, in a way, recognized for that. When Tom Ferris came and took over the department—I don't remember when it was—in 1982 or 1980, or something like that, he had a very strong department with a large amount of research going on, a very well respected department nationally. That was kind of the trajectory of the Department of Medicine, at least in the times that I knew it.

DT: Can you comment at all about your experiences working with Doctor Benson in the Department of Laboratory Medicine?

RM: Well, what I did there was I was pretty much allowed my own opportunities to work, and I was working on a chemistry project related to purine metabolism, the excretion of purines in the urine. I got interested in that, and that's what got me into hematology because the purines are part of the building blocks of blood cells. [And that led later to the year at Duke University] with James Wyngaarden, as one of his special interests was uric acid and purine metabolism. I don't even remember where I became interested in purines. So I was left on my own in the Department of Lab Medicine.

I took that opportunity to take Doctor [R.] Dorothy Sundberg's hematology course. She was the hospital hematologist or bone marrow specialist in Pathology, and she gave a course that residents took, and I took that course probably twice. I worked in the bone marrow laboratory for at least three months. So I did get some background in hematology. It wasn't like I didn't know anything, but it wasn't clinical. It was a morphologic background. In those days, there weren't training programs for people in clinical hematology because there wasn't very much to do. What did people in hematology have in the 1950s and 1960s? Well, you got the occasional anemia. People needed B-12. They needed iron. If you got leukemia, well, forget it. There wasn't anything to treat leukemia with in the 1950s and early 1960s—well, certainly in the 1950s. So hematology was one of these slightly esoteric specialties in a sense, where you managed people, but you really didn't have a lot to work with. Subsequently, of course, it's become heavy-duty stuff because these people have lymphomas and leukemias and you treat them actively. I never had that kind of training, and I never was in it actively enough to pick up on that, other than to treat an occasional patient. But, nowadays, hematology is big, heavy-duty medicine, including bone marrow transplants.

DT: I actually spoke with Doctor Benson last week.

RM: Oh, did you?

DT: I had good time talking to him.

RM: He is down at Thirty-fifth and...

DT: Bryant [Avenue South, Minneapolis].

RM: Bryant, yes.

DT: A very nice complex. I hear there are a couple of other physicians there that I need to speak with.

RM: Yes, I think Doctor Burchell was there. He just died [October 10, 2009].

DT: Yes, that's right. I think Fred [Frederic J.] Kottke is.

RM: Oh, is Kottke there?

DT: Yes.

RM: Kottke was the... That's where the Academic Health Center is located now. That's the house that Kottke built [Children's Rehabilitation Center].

DT: Oh, wow!

RM: Fritz Kottke built that it was said because he was a *big* supporter of the DFL.

DT: Interesting.

RM: He had a lot of Democratic connections and I believe this helped to get federal money to build that Children's Rehab [Rehabilitation] Center.

DT: That's great information. I did not know that. Even more reason to talk to him.

RM: He was really a pioneer in rehab medicine. One of the classic books [*Krusen's Handbook of Physical Medicine and Rehabilitation*] in rehab medicine was written by somebody at Mayo Clinic [Justus F. Lehmann] and Kottke. Somebody at Mayo Clinic and Kottke wrote this classic text on rehab medicine in the 1950s. Fritz Kottke was a big name in that. It wasn't any surprise that he got that big building. It never dominated in rehabilitation medicine here somehow because... Well, probably, referral patterns [and perhaps local competition, such as from the Sister Kenney Institute]...I don't know what.

DT: I'll be sure to ask him about it.

RM: Yes.

DT: One of the things that Doctor Benson had mentioned, and I had seen this in the archival material as well, is that there was some tension between some of the surgeons and the physicians within the Department of Lab Medicine. I think the surgeons were—I think it was mostly the cardiac surgeons—unhappy or dissatisfied with how rapidly Lab Medicine was doing their tests. Do you recall any of that?

RM: No, I don't. I wasn't part of that scene and I wouldn't have heard that, other than Lab Medicine was always... Under Gerald Evans and under Esther Freier, who was the hospital chemist, the drill was perfection. They turned out high-quality products. When they gave a lab result, they wanted to be sure that it was reliable. In doing so, they may well not have slopped stuff together as fast as surgeons or others might have wanted. I know that they ran into problems in terms of just volume. In those days, the hospital was running at a high clip. This was before the days of automation. In those days, they were doing BUNs [blood urea nitrogen], you know, with pipettes. Now, they run them through an automatic machine. In fact, they were very loathe to adopt, as I recall, those automated machinery for technology for chemical testing. Did Ellis mention that?

DT: He didn't, no.

RM: They were certainly not the first to jump into that, because they had this business of... Oh, I remember Esther Freier. They were always worried about the water supply and the purity of the water, how many tenths of a million parts and what contaminants. They were very, very meticulous about that.

Gerry Evans, when he established that department, that was under the aegis of the Department of Medicine. He was brought from Canada. He was an internist, too, I

believe. He established this department, which was a kind of first and that led to the Department of Laboratory Medicine and then merged with Pathology. I can remember when that happened. People were really worried about this humongous department. The Department of Lab Medicine was separate in those days, in 1960 when I was down there, and Ellis was there. He was a pathologist, and they ran the chemistry tests. Then it was merged with the Department of Pathology. But, that was kind of a first. Didn't Ellis mention that?

DT: Yes, he did. He did mention how important that department was, and it was, as you said, one of the first ones in the country.

RM: It was the first in the country. I think that's right.

DT: It sounds like it was, in terms of departments subsequently, a very important and effective department.

RM: Yes. You see, that's why they kept those standards up so high. They weren't really pathologists. They were doing chemistry. That's why Esther Freier had the title hospital chemist. It was a hospital where the pathologists were in one place with their tissue and their microscopy, and this "new area" of clinical chemistry was just being built up in Laboratory Medicine. No, that wasn't part of their drill. So they were keeping these standards very, very high as the residents went through their area.

DT: You mention Esther Freier. It struck me that there were a number of women who were in leadership positions in that department.

RM: Oh, yes. Yes.

DT: Do you know why that was? We don't see that elsewhere in other departments.

RM: Well, probably because most of the medical technologists were women in those days that were doing the pipetting. Grace Ederer [E-d-e-r-e-r] was one. She was Gerry Evans right hand person. She was kind of an administrator for the department, and Esther was the hospital chemist. There was a third gal there. I don't remember her name.

DT: Ruth Hovde?

RM: Ruth Hovde, yes, was the third one. I think their background was all that they were medical technologists somehow, and, then, they got recruited. How they got recruited by Gerry Evans, I don't know. They were certainly well respected. They had a big school of Lab Technology there.

DT: Do you know why it happened that most med technicians were women? Was this just...?

RM: I don't know why that would be. I do not know.

DT: I think Doctor Benson mentioned that none of them were around anymore. It would have been great to...

RM: I know that Esther Freier died [December 17, 1997]. She gave all of her money to the U.

I don't know about Ruth Hovde. She was older, I think, than I was, probably. [Ruth Hovde died February 9, 1989]

DT: Moving on to your time in administration, could you tell me a little bit more about what your responsibilities were as assistant dean of Student Affairs?

RM: Yes, I could. It was primarily to see students who had problems and who were willing to come to the dean's office and tell people about them. I'm sure we only saw a fraction of the people that really needed to be there. Most of them would be students with academic problems, having trouble with their studies, getting low grades, failing a course, and helping administer...well, what is going to be the remedy here in terms of a repeat exam or a make up course or that sort of thing, plus, advising senior students about their internships. That's how I got involved in knowing about hospitals around the country and helping students find good hospitals and, then, ultimately, to writing those dean's letters of support that the school had to provide for the students.

My brother [Terry] lives down in Green Valley, Arizona. He sees a dermatologist up in Scottsdale who is a graduate of this school. So he goes up to see him. He said, "McCollister? Are you any relation...?" "Oh, yes." He says, "Let me tell you a story..." [chuckles] Well, one year, in order to learn more about hospitals—a lot of our students were going out to the west to intern—somehow, I got the idea of making a tour of some of the major hospitals out there and just kind of getting a bird's-eye view of how they stacked up and so forth. This was in the days when information about hospitals was hard to come by, about the quality and experiences. I picked Oregon and this student happened to be interning at Oregon. Apparently, when I got there, what happened was this student was a young intern, scrubbed in, and they announced to him in the middle of the operation, "The dean of your medical school is out here. You better get out there and talk to him." [chuckles] I do not remember anything about this. This was Mark Dahl, a dermatologist now at the Mayo Clinic [in Scottsdale]. He told my brother about this. He said, "I had to go out there and talk to your brother about my internship and what was going on."

[laughter]

RM: I don't know how that ended.

So that was kind of what you did in Student Affairs. It was mostly people in trouble or people who wanted to have some special kind of dispensation. We didn't have a booked schedule. There weren't many people coming.

Then, I got involved in curriculum change and administrative work related to that and education development.

I was trying to think of how to frame something for you that, as an historian, you should know about and think about. So if I could just comment a little...

DT: Sure.

RM: This is sort of a global thing. During World War II, there was a large amount of federal money put into research in this country for the war effort, so large numbers of things were learned. Subsequent to that, things that I've read in various documents—they're not here—just generally, this society and a particular Congress got the idea that it would be a good idea to try to bring some of the goodies that were learned in the war in science and in medicine and in other areas, maybe even technology, to the people. Is this something that is resonating?

DT: It's familiar, yes.

RM: Okay. That, I think, is the impetus of what happened in this school, in a sense. What happened in the school in the 1960s was some of those goodies in that largess from the Federal Government was beginning to be sopped up here. People were applying for research grants. It was very easy. Even I got a research grants from the American Cancer Society. It really wasn't hard to get research money in those days. So it was flowing all over the place. I think that was part of what went on in this school that hit this school.

It was hitting a school that really was high traditional with a strong departmental structure strongly dominated by the Herr Professors, like Doctor Watson and others that were departmental powers. It was a strong departmental structure. I think that goes all the way back in this school, because in academia... What did Bob Howard say to me? The only words of wisdom he ever gave to me, or something, was, "The faculty controls two things: admissions and the curriculum." So the faculty, in other words, controls who they can teach and what they're going to teach. I suspect that goes back to the *Oxfordian* of Oxford. The faculty was in control of what they spoke and who they taught. In a sense, we had very strong departments. In to the milieu of very strong departments in this school came this surge of federal money from the largess that the Congress wanted to dish out. Congress created the NIH [National Institutes of Health] and said, "Let's give this money out to research." Number two happened when, guess what, the state legislature turned around and said, "We've got all these sick people, and we've got new healing methods, and we don't have enough doctors around here. What is the Medical School, the one and only medical school in this state [at that time], doing about it? In that time, just at the time when I got into the deanery, was a time of *great* turmoil here in the school, because they were being beset by the legislature on the one hand... I can remember the chairman of the House Appropriations Committee of the Legislature coming and speaking at the Mayo Auditorium to the faculty and telling them *what-for*,

which is saying, essentially, “You guys aren’t going to get money from the legislature unless you shape up. We need more doctors.”

That was the force that was going on. The doctor shortage at that time and the rise of science impacting upon departmental independence.

So along came the constitution. Along came the new committee and it says, “Well, let’s take a hard look at the curriculum. The curriculum up to that time was frozen. I mean, nobody could move. I can remember somebody wanting to get one hour out of biochemistry. It was viewed as practically a federal offense.

DT: [chuckles]

RM: The head of Biochemistry went up to the Dean and stormed. The curriculum was just *totally* frozen. What the curriculum did—which we can talk about later—was, in a way, initially, to unfreeze that.

I’m trying to give you this big scope of stuff. This happened to this school, and Bob Howard was the dean with *very, very* farsighted deaning, and he was totally not appreciated. He was kicked out of the school by the power structure that represented the departments and the status quo. I *know* that happened. He should have been first vice president [of health sciences], but he wasn’t. He was the Dean of the College of Medical Sciences [not, technically, the Dean of the Medical School though of course he was in fact] and, then, it was reorganized. In those days, the College of Medical Sciences included the Nursing School and the School of Public Health [and University Hospitals] under it. Then, that was dismantled and this Academic Health Center was formed. Lyle French was the first vice president [of health sciences]. Bob Howard, what was he doing in those days? Well, he got the constitution done, got Dick Ebert appointed head of Medicine, and he launched a new curriculum. He had a major retreat of the faculty—I can remember going to it down at one of the hotels west of town—on the hazards of federal funding. It turned out that the Medical School was becoming too dependent upon federal funding through research grants. He said, “This is going to blow up in our faces.” So he was trying to bring all of those things into the view of the department heads.

In the end, as I look back on what happened to the school, those fiefdoms were maintained. Whether they are now, I don’t know. They certainly were maintained into the 1980s. I think, in a way—I looked back at some of the reports of the curriculum when we had site visitors and thought back on things—that ended paralyzing the ability of our Educational Policy Committee to really make substantive changes in the curriculum until there had to be kind of a turning upside down. And there was one in 1984, which addressed needed changes. We were working around the edges improving the educational milieu with educational specialists and so forth, but really taking a hard look at what needed to be done in the curriculum... The curriculum reviewers pointed that out and said, “There seems to be no central administration of the curriculum.” I thought, yes, I knew they were looking at me, but when we took things to the Educational Policy Committee and we brought things up, and we had a retreat, things just didn’t

happen. I think that was partly due to the legacy of the very strong departments that either wanted to hold on to their powers and territories, like people in the Basic Sciences wanted to do, or the clinical people who probably were beset with many other things and really couldn't turn their attention to improving, let's say, their clerkships or other educational parts of their programs because there wasn't enough money or interest or whatever.

I can remember I said this to any number of people. One time, I got the idea that we really ought to have established performance criteria. I mean, all these graduate physicians going across the stage at the Northrop [Auditorium], do we really know anything about their competencies? So one time, I got the clerkship directors together, and I said, "You know, we really need to have some criteria. Let's just start small. How about the Department of Medicine just taking on a few of these things, like to be sure that, for example, the students know how to take a blood pressure correctly?" I mean, that sounds fairly simple.

[chuckles]

RM: Or auscultation of the heart, just a couple or three things. Then we'd know that we've vetted the students, that they *all* know how to do this just right, and then build on these competencies. Did I get any takers? I got no takers. Of course, you'd have to have evaluation mechanisms to test them, like, okay, you're going to have somebody learn about auscultation of the heart, you're going to have to give them some structured unknowns and not just rely on... "well, I think I heard a murmur doctor but I did whatever."

Well, of course, that's what—to bring you up to the modern day—Medicine 2010 floundered on. It's what Medicine 2010 is supposed to do. It's got all of these criteria and outcomes measurements that everybody is calling for. That's going to take *a lot* of money, a lot of resources. I think that's what Frank [Cerra] saw, that, plus some in the Basic Sciences. I think that's why he put it on the back burner. Outcome measurements are very expensive, and they're hard to come by. You have to have reliability when you're testing medical students and really making it important.

One time, I went to southern Illinois where a neurologist was heavily involved in the curriculum. Neurologists have these compulsive people. They had imposed problem-based learning there. As an extension of problem-based learning, they had put in evaluations of students with unknown patients. We're going to have unknowns. And these would be senior students. You're going to have five unknown patients. These are going to be programmed patients, actors or whatever. You're going to have to go through the right things, do the right things, come up with the right conclusions. They found out that some of the students failed. Some of the students missed a couple or three of the patients. Then, the faculty was faced with this dilemma. This is a senior student. He's passed all of these things up to this point. How reliable is this particular evaluation if you're really going to fail somebody and prevent graduation based on it? It's a very interesting dilemma that the measurement people have, even now, on this kind of clinical



measurement. If you're going to enforce it, it has to be reliable and, then, you have to be sure is it fair, in a sense?

DT: Presumably, as well as being expensive then, that requires a different level of commitment from the clinical teachers to actually teach better and to, then, do the evaluations as well?

RM: Yes, absolutely. That's right. They have to have objectives of what they're doing. Okay, now, we want to be sure we cover all these things. So it gets all this structure, which sounds logical, but, in the doing of it, in the way the clerkships are run, that's not the way the clerkships have run in the past. Whether they will in come to that point in the future or how they will, I don't know. Maybe automation will solve some of this. It is a big dilemma. That is what led, I think, Medicine 2010 to get put on the back burner.

I elaborated on the issue of clinical departments not having enough resources and the Basic Science departments not wanting to give up their piece of the pie because that was their one place that they're on stage. And the students, if they don't teach microbiology that way, those students will never learn and, by golly, we need this much time on immunology. Don't you think immunology is important? We can't cut back on...and that sort of thing. After all, they've got *four* years in the Medical School, and we only have 130 hours. So that was the tension in that thing with the strong departments in changing the curriculum.

I wanted to kind of sketch the background of this. As I thought about it this afternoon, I thought that was really an outcome of World War II with the growth of science spilling out of goods, in a way, from the government to the populace and, then, the populace saying, "Yes, and we need some doctors to deliver this." That's what caught this school in a big crunch in the 1960s, which led to the formation of the new two-year Medical School in Duluth and all kinds of other things.

DT: Do you think the department fiefdoms were maybe unique to Minnesota, but the problems with regards to excessive research funding and not enough attention to education was something that was more universal?

RM: I think that was. The fiefdoms were certainly not unique to Minnesota. I think that was just part of the way medical education grew up.

The first glimmerings of just looking at teaching medical students from an educator's point of view was done by George Miller at the University of Chicago. I don't know when that came about. *Teaching and Learning in Medical Schools* [Doctor McCollister refers to the volume on his desk.] Nineteen sixty-one. That was when people started to look at it and George Miller was the first one.

Incidentally, our Ilene [B] Harris, who worked under me, worked with me for twenty-five years improving the education scene here, is now the head of that unit.

She's interim head of the Department of Medical Education at the University of Illinois. That's quite an honor for Ilene.

DT: Yes, that's great.

RM: She left here a number of years ago—not that many years. She was here with Greg Vercellotti. She left in 1997, 1998, or thereabouts.

Anyway, that was the first time that people interested in education really began to focus on the likes of how do we do this, how are we doing this...on the process. Now, it's come to the point where Lindsey Henson is the vice dean for education, and she's been thoroughly schooled in this drill, as has Linda Perkowski, of course. Both of them are experts in the education scene, developing objectives and outcome measurements and that whole business. So that's what they're trying to improve here. That's what we improved while Ilene was here. When we started out, we were one of the first. I remember, way back in the 1960s, the Senate Education Policy Committee of the University got the notion that all of the courses in the University ought to be evaluated. I thought, hell, we've been doing that. Every one of our courses had a formal evaluation. That was being done fairly early, but courses being evaluated is different from precisely determining what had been taught. Yes, we give the finals, but that doesn't necessarily tell whether students have reached certain criteria that you valued. So that's kind of what the modern-day people are trying to do.

DT: That's all very interesting. Yes, and to bring it up to the current period, as well. I don't know a lot of that information. I know a little bit about Curriculum 2010. Some of what you said, I've heard from other people as well, that 2010 is what should have been instituted a long time ago, maybe.

RM: Yes. That's right. It's very definitely a work in progress. I can remember trying to get those clerkship records of performance by students to be identified. I don't know where I even got them. I wasn't any magic person. I'd get these ideas. But that is exactly what you need to do. You need to have some absolute criteria that you can be sure that they can complete, that they're important, and everybody could chime in on that. The pediatricians...okay, they could start with three or four. Well, in the end, you know the idea would be you could have a whole array of these things and you could feel pretty good or build on those. Of course, that's going to take resources.

DT: Can you say, then, some more about that process of revising the curriculum? What went into it? You talked about the impetus for the curriculum change, but, maybe, some of the ins and outs of that process...

RM: I think the curriculum here was... Again, it's important who you know. At that time [in the mid-1960s], the major place that any medical curriculum in the nation was being innovated in the United States of America was the Case Western Reserve University. They were the pioneers of changing medical education.

DT: Hmmm.

RM: They had a very innovative curriculum including having freshman students be assigned a mother, a pregnant woman, and were expected to follow her all through her pregnancy and, after nine months, would hopefully be at the delivery. That was pretty revolutionary. They had organ system programs in year two and were trying to bring pathophysiology... Those were the big words. It was pathophysiology rather than, oh, you're going to study anatomy, you're going to study pathology, you're going to study...all these little silos of information. Pathophysiology is trying to bring them all together. You'd say, "Let's study atherosclerosis and heart attacks and what all happens. Let's talk about the physiology of that. Let's talk about the pathology, how it happens, the symptoms relating..." That's pathophysiology as opposed to the pathologist talking about, "This is what we see in a heart," and, then, the internal medicine people saying, "This is the symptoms of somebody who's going to have a heart attack." That was going on at Case Western. In those days, that was *the* place where American medical education was being experimented with and on.

RM: So guess who was head of medicine at Case Western Reserve? None other than Robert Ebert, and his brother Richard Ebert was head of Medicine here, and he was head of the Curriculum Revision Committee. So it was no terrible surprise that our curriculum got modeled after the Case Western Reserve innovation in medical education, which truncated basic sciences with early introduction to clinical medicine. We didn't have a pregnant patient program, but we did have students getting involved seeing patients earlier than the second year, which is when they used to do it. In the old day, students never saw any patients till they were in the second year. Then, they had physical diagnosis early on. Now, in fact, they link anatomy with physical diagnosis. Even now, Sharon Allen links students in their freshman-year anatomy with physical diagnosis learning. It's a logical place to do that. You've got all these landmarks and boney structures that are physical landmarks that you're learning. You might as well think about physical diagnosis, too. That was Case Western Reserve and the pattern truncated basic sciences with early introduction, pathophysiology in year two, and, then, a series of clinical experiences in years three and four. As I said, the Ebert brothers were, I'm sure, communicating frequently. They were both internal medicine heads of departments, and so it's not any surprise that that came about in the course of the discussion and the course of planning and the curriculum.

How that went on, I don't know. It was decided that there would be certain phases of the curriculum. Phase A would be the basic sciences and Carl [B.] Heggstad was—he's dead now; he died—an anatomy prof [professor], and he was made head of Phase A. I was in charge of Phase B, which was the pathophysiology. Phase C was going to be the required clinical clerkships with Richard Varco, who was a noted surgeon and power structure around here. He has also died. He was head of Phase C, which never was implemented. Then, Phase D was going to be the return to basic science and the electives and so forth. I think Ellis Benson was in charge of Phase D. It was made into segments. They had members of the committee groping how is this going to fit together and how do we put it together and so forth?

[pause]

Oh, yes, I believe we forgot a major curriculum development that was going on here in the 1960s, which was the Comprehensive Clinic.

DT: I have that written down to ask.

[laughter]

RM: Well, the Comprehensive Clinic Program was extant when I first went into the deanery. It was headed by an internist and a pediatrician, Jim Carey and... I've forgotten who the pediatrician was. The idea was that students had their regular first two years in the Medical School. A third year was the required clerkships. In those days, the to schedule students for the required clerkships took about five minutes, because all you did was take all the names and divide things up and... Nowadays, detail scheduling and all kinds of flexibility is much more desirable. But, in those days, students spent the third year on the clerkships, period. Then, the fourth year had been designated the Comprehensive Clinic Program and the electives and free time. There were three months of free time. There were three months of electives. And there was six months of the Comprehensive Clinic Program, which was situated in the old clinic that was located on one of the floors in the building here. Anyway, it was in the Eustis Wing, the Comp[rehensive] Clinic down there, and it was the University Hospital clinic for indigent patients.

One time, Doctor Graham Beaumont, who was a young internist working down there, from Britain... Graham did a study of the most common diagnoses that the students were having in their assigned patients—they were all assigned patients there—in their rotations, and it turned out to be interventricular septal defects because we had many cardiovascular surgeons here and that clinic was the intake site for such patients. It was not sufficiently broad-based... It was not Hennepin County Medical Center downtown. It was a very specialized clientele that came to the University Hospital and they ran through that kind of...

The concept was a great idea. The Comprehensive Clinic was based on very good ideas about comprehensive care, about many things that family practice espouses now: total body care, comprehensive longitude. All these buzzwords were being implemented in a setting that was impossible to implement. It came to the end of its time. It was superseded by the new curriculum, and it was essentially done away with when the new curriculum was implemented. I don't remember all of the death throes of that at all, because I wasn't part of it. I was one of the agents. I'm sure that the two doctors who were running it didn't exactly think I was terrific either, but I don't know that Jim Carey ever came and blamed me about the new curriculum. It was just that they tried their best and somehow that didn't quite work. It was the, then, senior year program of the Medical School. It may have been funded through a special grant, maybe something like a foundation grant. I don't even remember how it got money.

DT: I spoke to Dick Magraw, who was involved with the Comprehensive Clinic for a while, and I don't remember if he said how it was paid for, but I can ask him again.

RM: Yes, that's right; Dick Magraw was involved in that, too, he and Jim Carey and the pediatrician. I'm sure he was kind of like, oh, one of my favorites, Joseph Campbell.

RM: He's one of my favorites, *The Power of Myth*, that series.

Very possessed of things, Dick Magraw, and a very smart guy. He was far-reaching and far seeing. In fact, he wrote a book on new directions in medicine called *Ferment in Medicine* [ : *A Study of the Essence of Medical Practice and Its New Dilemmas*]. I remember one of the young internists smartly saying—I can name him, but I won't; he was one of the people who was slightly junior to me—"Oh, that book that Dick Magraw wrote. What's it about? Enzymology?" No, it wasn't about that, but it was about what was going on in medicine and the kinds of things that, now that I think of it, really led to the revolution in primary care and in family practice.

In fact, that's what happened under Bob Howard and under Dick Ebert. That was another thing Doctor Bob Howard did, essentially under the stimulus of the legislature. The Medical School expanded. I was part of the Physician Augmentation Program of the NIH that did that and helped expand our Medical School. It just blew the place apart when we expanded. We increased the class size by sixty-five overnight. We got a lot of federal money. There was a big bunch of federal money. So the Medical School expanded the class size under the stimulation of the legislature, created a Family Practice Department, turned the curriculum around. It was all these things responding to societal needs in those days. That was part of the stimulus, the federal grant program.

I suspect that Comprehensive Clinic that Dick Magraw was central to must have gotten money from somewhere, and I don't know where. I think it was established about 1960.

DT: I think so, yes, 1959, 1960.

RM: I remember when I was chief resident they were talking about it in the department. I'd been out at the V.A. or in the lab, so I knew nothing about it. Sure enough, there I was chief resident, and they were talking about the Comprehensive Clinic Program that was going to come about. I now vaguely remember hearing about that. Then, ultimately, I was part of finding a successor to it.

DT: That's interesting. When I spoke to Doctor Magraw, he placed the emphasis on the development of Family Practice, that the Department of Family Practice kind of superseded the need for the Comprehensive Clinic or, at least, the powers-that-be decided the Comprehensive Clinic wasn't needed. It's interesting that you put the emphasis on the curriculum.

RM: The Family Practice Department [initially did not have a big role in the new curriculum]. It was established in 1969, and the first head of it was an internist, and it was sheltered in the Department of Medicine. It was a division of the Department of Medicine. He probably mentioned that to you. It was headed by...

DT: Ben [Benjamin] Fuller.

RM: ...Ben Fuller. Yes. Ben is gone, too. Ben was another one of those wise people.

Did you ever read that book *The Wise Men* [by Walter Isaacson]?

DT: No.

RM: That's another one of my favorites.

Ben was one of those wise people. He was very smart. I remember one time more recently, before he died, I saw him at something and he said, "You know, one of the major fundamental flaws that's happened at this school, just in general in terms of medical manpower in the state, is that there's been an overemphasis on family practice and not internal medicine." We're both internists, so I probably heard what I wanted to hear, but it is true that internal medicine has a lot to offer in terms of the sort of comprehensive care and the growth of need for elderly, people with diabetes, people looking for specialists, and family practitioners are not necessarily trained to do that sort of thing. I think what he meant was if a little bit more emphasis had been given to the training of the general internist, it could have gone a long way toward solving some of the manpower problems outstate, because those specialists might have attracted others, other specialists; whereas, family practitioners don't necessarily attract other specialists.

DT: Interesting.

RM: It was interesting. He thought a lot about that, and I thought that was a wise statement. Anyway, he was the first head of Family Practice at the University of Minnesota.

But I don't think Dick Magraw was right about that. The revised curriculum was established in 1969, and that's when the Comprehensive Clinic became obsolete, in a sense, because the third and fourth years turned into what became known as "tracks." What happened was the required third year clerkships didn't remain. Here's where logic fell down. The logic was you got this early introduction of the clinical medicine. You got truncated basic sciences. You got pathophysiology. And, then, what's logical? Well, the logic is all these people are going to specialize. Guess what happened in 1970. The years of specialization began. Nineteen seventy-five was the last time people could go out into... Well, you could still go out into practice if you had a year of internship in Minnesota, but it was, essentially, the last time that people took a one-year rotating internship and went into practice. In 1970, everybody specialized. So the logic to Ebert was—he was a very logic-minded—everyone is going to specialize; therefore, we ought

to have tracks or pathways that lead those third- and fourth-year students to those specialties. Each of the students then picked a track. So the tracks develop kind of an organization unto themselves and thereby fragmented, in a way, control of the education of the third- and fourth-year students. Oh, they're in the family practice track or they're in the neurology or what are they doing over...? Each of the tracks had different requirements and some of them didn't have very many requirements at all. Family practice had the most. Every student needed to take six weeks of medicine, six of surgery, six of peds [pediatrics], six of obstetrics. Some of the tracks, such as surgery felt students could have a little medicine and some surgery [but the balance would be up to the student and adviser]. That went on for quite a number of years. We had these pathways and tracks, and they were supervised by the track committees.

In the end, the faculty decided—I think rightly so—that there were people falling through the cracks. There were people graduating from the Medical School who'd never had any OB [obstetrics]. For example, one track aimed at psychiatry felt student didn't need OB [obstetrics]. But, the counter argument was you know they're doctors. What if they are on an airplane and a delivery occurs? So there was that kind of discussion that started to bubble, bubble, bubble.

As a result of that and other things, the curriculum was changed. I can remember going to the students saying, “Students, we have come to the end of the tracks. We are not having tracks anymore. We will have the following program.” What we had then was required clerkships for the students including medicine, surgery, OB, and psychiatry; neurology was added as a requirement later], and then electives in a variety of ways. What we also had was the three months of free time that had always been in the Comprehensive Clinic Program. Then, there had been a three-month free time in the freshman year that had been used up, so students didn't have that summer vacation after the freshman year. That ended up being put into a bolus of six months or five and a half months of available free time in what was called the junior/senior biennium, that two years of the junior/senior program in which they took the clerkships, took their electives, and then there was this five and a half months of free time.

Well, it's turned out that that free time was extremely fortuitous. If you'd ask the senior students—and we did every year for years—“What are the good things about this curriculum?” I can tell you what they said year after year. The free time and the flexibility of the scheduling of the free time and the other courses, and number two, the strengths of the clinical rotations at Hennepin, the V.A., and the affiliated hospitals. They were two things that saved us. It wasn't the basic sciences, however good they are. It wasn't pathophysiology, though the students liked the Year Two program. That was always popular. But the real strengths of the clinical part of the curriculum were the flexibility, the six months of free time. If you look at medical school curricula around the U.S., you will not see that degree of flexibility. That exists even to today. Most of it is retained. A little bit of it has been sopped up—things that I fought against but it didn't make any difference—a required clerkship in emergency medicine, for example, which I thought was emergency medicine's desire to get its place in the sun, which they have.

That's how the curriculum mutated from the original program, which was logical tracks. Everybody was going to specialize. Now, they, of course, do different things. They take different electives. They do different things in their free time, having people who will do orthopedic research and take additional electives in ortho. Other people will do other things. That happens, and it happens in a way on the student's volition with the help of their advisors rather than the track and pathway kind of having this artifice, which artifice ended up shortchanging some students with kind of a breadth in education that probably is desirable in all physicians. It was a mistake to have a lot of that to be quite so loose.

DT: You had mentioned the Phase C of the revision.

RM: Yes.

DT: What is Phase C?

RM: Phase C, as Doctor Varco wryly noted at one of the final retreats, "I guess Phase C has just been phased out," or something. It essentially was going to be required clerkships, but because the control was turned over to the tracks, it was thought there isn't a need for a required clerkship in medicine and surgery. The tracks were all going to do this. Well, in fact, the tracks didn't all do it or it depends on what you thought was required. If you thought OB was required... Certainly psychiatry didn't require OB. Pediatrics, I don't even remember. Pediatrics may well not have required surgery. You can imagine...well, there you are.

DT: Basically, once the tracks ended though, Phase C was implemented it seems.

RM: In a way, that's right.

DT: It was just in a different iteration.

RM: Yes. I hadn't thought of that. That's right.

DT: Do you remember the date when the tracking system was...?

RM: Nineteen eighty-four.

DT: Okay. So it was quite a while...

RM: Yes, it was. There was a curriculum revision that was headed by Dodd Wilson. In 1984, that was changed and we came, essentially, to the end of the track system.

DT: One of the things that I notice from the archival material is that in actual fact in the mid 1960s, even students were asking for more flexibility and changes in the curriculum. I saw some material... There were three students who wrote in 1966 and, also Accreditation surveys were noting that students were dissatisfied and that they were asking for more flexibility in the program, less emphasis on memorization, more



opportunity for supplemental learning and more patient contacts. But it seems that even if that didn't have an influence, this was something that students wanted themselves.

RM: Yes. Now, that reminds me... I know we did surveys of both students and of faculty before the curriculum was changed to hype up the situation. Look at what all the people think. We've got to change it. There was a certain momentum that had to be developed in the mid 1960s to get everybody on board saying, "Oh, yes, we really to change."

Certainly, the basic sciences in the first two years had not changed at all in years and years. The clinical instruction had changed under the Comprehensive Clinic Program, but that was not exactly the students' favorite. There was a lot of [formalized structure and activities in the Comprehensive Clinic]. They had various kinds of things that were put together for the students to do. I don't remember what they were, but they included papers or exercises. After all, those senior students had six months in this Comprehensive Clinic and many sites did not provide a rich milieu for clinical work for them. So they had to develop other things. I think students, for example, in the afternoons could go to the Urology Clinic, or they'd spend two weeks in one or another clinical area. So they had this little potpourri of miscellaneous clinical goodies that they were trying to learn about. It was hard to administer that. It was all over the place.

The students when they were complaining of memorization, I suspect they were talking about year one, the freshman year.

DT: It seems like this tension, or resistance maybe, from the basic scientists continued through the 1970s, that there were periods in which the basic scientists were arguing for more time in the curriculum. It strikes me that this might be something that's always there, that there's only so much time in the curriculum and, as you mentioned earlier, everybody wants a piece of the pie.

RM: I think so, but there was not a lot of screaming about time in the curriculum. Ummm... Well, I shouldn't say that. You're probably right. They were caught up in this wave of curriculum change when the curriculum was changed around 1969 and 1970. Then, particularly in Pathology... See, Pathology was really given a very small amount of time to present their content. Some of it was woven into the clinical pathophysiology in year two, so pathology didn't feel that they had a presence and an impact on the students. So I think that was to some extent changed.

DT: I noticed that Behavioral Science was included in the curriculum in 1973, but that followed several years of debate. Is that right?

RM: Yes. Behavioral Science was a very difficult area. Nobody knew quite what Behavioral Science was or what we were trying to teach. There was a former course in...oh, I've forgotten, psychopathology or something like that. I can't remember what it was. It was taught by Psychiatry. I don't remember the details of that, but I know Behavioral Science was a problem. In fact, it was truncated later. I think Tom McKenzie

volunteered to cut Behavioral Science because it had a large number of hours, I think over thirty in the revised curriculum. Then, when the curriculum was changed in 1984 or thereabouts, Tom said, "Psychiatry will teach that, and we're willing to do it in fifteen hours. If you guys would like my other hours, you can have them." I've forgotten who took them, but maybe Pathology.

DT: Other material that I saw related to the curriculum revision was concern that the students who were transferring to the U from the University of North Dakota and the University of South Dakota. There was concern that some of those students might not be up to scratch. Now that the revisions were being incorporated there was concern how would the U ensure that the transfer students could fit into the revised curriculum and be at speed as soon as they got there. Do you recall any of that discussion?

RM: [pause] Well, no. I'm trying to think. We did have contracts with the Dakota schools. We had two things with the Dakota schools. At one point, the Medical School took about three students each year from each of the Dakota schools into the third and fourth year program. I don't remember how that linked when we had the tracks or even if that occurred. We did have a very large contract with the North Dakota school [at one point around 1980] to teach thirty-five of their students the basic clerkships. They were assigned regular clerkships [in their third year and then went back to North Dakota for their senior year and graduation]. That was all there was to that. The school got a lot of money for that. We really had to dilute our resources because we had very large classes at that time. We had a class of 230 ourselves when we had in addition, the thirty-five Dakota students. We had very large clerkships. I know that student evaluations would reflect the fact that there was dilution of experience.

DT: The Educational Policy Committee that you staffed, that was overseeing the curriculum revision? Is that right?

RM: Yes.

DT: And, then, they continued to oversee what was happening with the curriculum?

RM: Yes, that's right. Do you want to take those with you [Educational Policy Committee Annual Reports, 1968-1995]?

DT: Yes, that would be great.

When did you become associate dean of Curriculum Affairs?

RM: Oh, I think it was probably in the mid 1980s. It was when Neal Gault was still dean and that was before 1984, because he left in 1984. So, it probably was in the early 1980s that I got promoted from being assistant dean to associate dean. My major role was in curriculum beginning in 1975, probably. Student Affairs then was taken over by Al [Alfred] Sullivan in the early 1970s. I didn't do Student Affairs then. I was doing curriculum in the 1970s.

DT: Okay.

Another thing that it looked like the EPC was involved with was the establishing a program in Human Sexuality in the early 1970s.

RM: Yes.

DT: Do you remember much about that?

RM: Well, that was a program that got woven into Phase B curriculum. There were a number of people pushing that. Rick [Richard] Chilgren, a pediatrician, was pushing that. I've forgotten what other people. It got incorporated in... You may see that in the old archives someplace; I don't even remember when that occurred. I don't remember whether that was part of the very first curriculum or not. [pause while Doctor McCollister reviews files on his desk]. This is 1967. You're going way back.

DT: Yes.

RM: And here's Medical School archives. Here's the gist of the comments. These were comments we took from the faculty about how the curriculum should change.

DT: Oh.

RM: They're identified as faculty and the gist of their comments. There are four pages of that. Phase B. Here's Phase C. Let's see, Phase D. [pause]

Let's see. I'm looking at Phase B, and I do not see Human Sexuality there. I'll bet that was a later development.

DT: It seems like it was 1970, 1971, maybe.

RM: Okay. Yes, then that would fit, because the curriculum was... Here's the report for the executive faculty of October 1969: "A committee continued to develop the plans for a new curriculum." Let's see. [pause] The freshman class increased in 1970. I'm trying to see when the actual curriculum was started. I think it was 1969.

DT: Okay.

RM: You'll be able to see it. These are all here. Isn't it nice that I saved these?

DT: That's great. Oh, this is what we historians love. [laughter]

RM: Historians... Don't lose them. This is the only copy.

DT: No, no, no. You don't have to worry about that.

I have lots of other questions, but I realize we're pushing up on time. I'll not ask too many more.

RM: Okay, sure.

DT: We'll just pick this up in the spring. [laughter]

RM: Okay.

DT: Maybe this was when you had shifted away from medical student affairs to curriculum but another change that seemed to come about at the end of the 1960s was this effort to include minority students.

RM: Oh, yes.

DT: Can you say anything about that?

RM: Yes. That was a big event. One of the prime movers in that was Charlie McKhann, M-c-k-h-a-n-n, I think it is. He was a surgeon. He was from Harvard. He was eastern trained. He was one of the spark plugs of that. I suppose this would be the early 1970s. The Admissions Committee admitted a lot of people that were not terribly well prepared to study medicine, and they got into a lot of academic problems, and a number of them had trouble getting through. There was a great deal of turmoil.

I can remember one of the pathologists was from Britain, and he had spent a large amount of time in Africa. Have you heard this story?

DT: No.

RM: Oh, I see. Okay. You have an accent that makes me think you're from... You're not from Quebec?

DT: I'm from Britain, yes. [laughter]

RM: He had a large number of slides from his work in Africa. Guess what color all the people were?

DT: Yes.

RM: And we had black students there and they challenged him. They challenged the administration. They made such a scene. Is this pathology? All you're showing are these black people with diseases. Well, nobody ever thought about it. We hadn't even thought of this. So he [the pathology lecturer, a very popular teacher], got into trouble. I think there were people that were almost even physically threatened, because sometimes faculty would make a comment in a lecture, and it would be taken wrong. So there was a

lot of turmoil. I was not in Student Affairs at that time. The decision to increase minority enrollment was done by the Admissions Committee, so the people who got mostly involved with that were [those in Student Affairs, chiefly] Al Sullivan... But there is one person... Al has died, of course; everyone is gone. *But*, I have another who can help you.

DT: Excellent!

RM: There's one person around that would probably be able to talk about that to you. I wonder if you've even heard her name. Have you? Linda [F.] Reilly.

DT: I have not. No, no.

RM: Ah! I knew I'd be helpful.

DT: [laughter]

RM: Linda Reilly, R-e-i-l-l-y. She sits in a grand office right outside the door of the senior dean for Education, Lindsey [Henson] down on the C. corridor. She's, essentially, the administrative person that runs the Medical School education support scene now.

DT: Okay.

RM: In the 1970s, she was working in Student Affairs with Al Sullivan, so she will remember the students. She will remember the details [of the many problems students and administration faced in the area of minority recruitment]. To tease out elements of that, she would be valuable if you really want to talk to her.

DT: Oh, yes, for sure. That's great. Thank you.

RM: There's one other person who would really know about this area, namely B. J. [Barbara] Gibson in Financial Aid. She's another person, but Linda, I think, was a little closer with the students. She was the secretary for Admissions, so she knows all about how the Admissions went. When you look at the Admissions books—I'm sure you've seen them—you surely don't see very many women and you don't see many minorities way back, I would bet, in 1969. I don't remember that until the early 1970s.

DT: Yes. It looked like in, I think, 1970 there were maybe four Afro-American students taken on that year, and I think maybe it increased to six the year after. But it was still pretty small numbers.

I remember this discussion in the archives [material] that there was concern about preparation for medical school... I saw some document that said, I think it was in 1969 or maybe it was 1970, once people were being rejected, they sent out a card that asked anyone who identified as a minority student if they would report back. Then, I guess there were twenty-five replies. Then, among that twenty-five, it seemed like maybe a

couple were identified as being able to be admitted even though they hadn't made the first cut.

RM: I see.

DT: That's what it looked like.

RM: Yes, they might well have had that approach, because you'd have to have people that applied and they might very well not have gotten in. They have an initial screening where they look at the GPA [grade point average] and the MCAT [Medical College Admission Test] and they say, "Well, now," and they put those aside. So, yes, that would sound logical.

DT: It seemed like there was a question of how to even identify disadvantaged or minority students, because there was no way of finding out someone's race or...

RM: Yes, that may be true.

DT: It was illegal to ask someone's race. So I think that's maybe why they asked for self identification.

RM: Yes.

DT: I'll definitely try to interview Linda Reilly.

RM: She'll know about academic problems and just kind of the general scene of that. It reached a zenith someplace, and I don't know what happened. She would know better whether the numbers were trimmed back or whether the qualifications of people got better or if they were more selective. Maybe in recruiting, they reached the net out more to find more qualified people.

DT: Yes, it seemed like there was actually a specific recruitment effort of going into different communities, and the Native American community, as well, and trying to pull from there.

RM: Yes.

DT: That's great. I'll talk to her.

Another thing that seemed to change—this was, I think, in 1979—was that the medical students...

[break in the interview]

DT: ...were active in having a medical ethics course included in the curriculum?

RM: Yes, there was that group of students interested in that. Who was that student? Linda would remember the name of the student. I can almost see him now, but I can't come up with his name. It was [not an area of special focus in the curriculum. Rather, appreciation of this was more taken for granted]. I certainly didn't push it, and I don't think anything happened. I think what happened was an attempt to get some kind of either an elective or a volunteer kind of a group that the students could go to or whatever. It was one of those where administratively we fudged it and didn't respond.

DT: Interesting.

This is changing tack a little bit. You had mentioned earlier about Dean Howard's deanship and some of the troubles that he faced, but, also, the great achievements that he made. Then, you, also, mentioned the fact that he wasn't appointed first vice president [v.p.]. Can you elaborate on what led to Doctor Howard's departure and the appointment of Lyle French as senior v.p.?

RM: Ummm... I think that... I *think* that there was concern that Doctor Howard was going to establish some kind of faculty practice plan and take money away from all these departments and also the high-rolling surgeons. They got all exercised about it. What they did, I don't know...may well have gone to the president and said, "That's not going to work. The whole school will blow up if you do this." Bob Howard, as I already mentioned, had had that retreat and said, "We are coasting on soft money here that is dangerous. We need to do something about it." Well, where are you going to get other money? It's going to have to come from the clinical practice of doctors. It's not going to be from the basic scientists, and it's not going to be from the state. The state isn't going to give anymore. If the Federal Government gives money for physician augmentation, which they did, it ended up being used largely for clinical education. Certainly, the contract for the North Dakota contract students was money that was used for clinical activities. So if you stop and think about it, that was the logic of that, you see, and they saw that coming if he was the v.p. And who knows, he may even have announced that. I don't know.

[laughter]

RM: I don't have any papers on that. That was my surmise, that the power structure was Lyle French being a neurosurgeon and some of the psychiatrists that he knew, like Don Hastings, who was head of Psychiatry, and probably Dick Varco, who was a very, very well known cardiac surgeon, and [C. Walton] Lillehei. Who knows? They all probably thought, this [faculty practice plan and the controls attendant to it] is not going to happen here. That's part of that business.

I was thinking of pointing out to you in a sense that... [pause] You could look at institutions two ways. You can run them like the Mayo Clinic does now. What's the ethos of the Mayo Clinic? Staff physicians, [at least in the past], did not go to the Mayo Clinic to make a lot of money. That was and is not the ethos of the Mayo Clinic. It is highly professional [and traditional even to the mode of dress]. People all wear suits and

so forth. It's well known: they do not make tons of money down at the Mayo Clinic. They've got a terrific reputation, because they all put in their markers to the *institution*. At this place, what do you have? Fiefdoms in departments where you have clinical surgeons and expert people, who, historically, have not put their markers in to the institution. They've wanted to keep it for themselves [or more closely, in the department itself]. As you look at it historically and you think about those two institutions, isn't that interesting? They're only seventy miles apart, and there's a world of difference between the ways they've operated historically. One, they put their markers into the institution. If I'm here for the Mayo Clinic and we're going to make this place really great, and it has. But, at the University some, not all, have not done that for some reason. Whatever. Maybe it's part of what you need to get brilliant investigators or I just don't know. But, I think that thread runs through here.

I don't know that that ever did [make it] into Leonard's book [Leonard Wilson, *Medical Revolution in Minnesota: A History of the University of Minnesota Medical School*]. He was commissioned by the surgeons to write it, and I don't think it ever reflected that, his book.

DT: No, I don't think so. No, there's really not a whole lot of attention on the Mayo as another example, but also on the fiefdoms.

RM: [unclear]

DT: The culture, yes.

RM: The culture. Yes, that's the word. It's kind of interesting.

DT: Maybe if I can ask one final question?

RM: Yes.

DT: Then, we'll reconvene this in the spring. Obviously, the Health Sciences were reorganized at the end of the 1960s, and in 1970, you have the Academic Health Center being created.

RM: Yes.

DT: I wonder if you know much about what the attitudes were of the medical faculty, but, also, maybe how that influenced how the nursing faculty felt about it, dentistry, public health. How were relations? Obviously, they were part of the College of Medical Sciences. Do you recall how relations were?

RM: I think Lyle French did that in a very unobtrusive way. He had a very small operation. You wouldn't believe it. Of course, you're attached to the Academic Health Center, aren't you?



DT: Yes.

RM: I better be careful.

DT: No, you're fine. [laughter]

RM: Frank [Cerra], he would... Well, what could he do?

DT: He's really committed to having honest representations...

RM: Frank has done some very nice things. I really admire Frank for a *lot* of the stuff that he's done. You can go up and down the hall and people are not happy about Frank, but I suppose you can make a lot of enemies there. I can remember when he was dean. He was dean for one year in between 1995 and 1996, right in there. One of the first things he wanted as dean... I was running the Educational Policy. He said, "We need to do something about alternative care." I mean, he pushed that. We had a big retreat over at the Weisman [Art Museum] thing, with all these people [not exactly in the mainstream of what was then thought to be medical care]! We had B. J. Kennedy and all these cancer research faculty saying, "What are these people talking about?" But Frank was way ahead of the curve there, and Mary Jo Kreitzer and her stuff. He was right on. Now the NIH has established a section in that area. So that was one of the things that he did. I've always thought about that and other things that he's done. He's been forward looking in appointing an historian to kind of capture the treasure of history, like yourself, getting oral histories. That was all very positive, what he did.

Now, I lost my train of thought.

DT: I was asking you about the attitudes of maybe the Nursing School...

RM: Oh, yes. There was Lyle, and he had a very small office. He had one secretary, and Dave Preston, who was a former hospital administrator, worked with him. That was all. At some point, he got John LaBree back from Duluth to work in there. He had an office of about three people; that's all they had. They didn't have this large staff, like Frank who has got these education people. He's got the testing centers. He's got all these different centers, the communication staff, such as the head of the Academic Health Center communication [Mary Koppel]. So Frank has developed it, but at the beginning it was very small, very collegial, and I think all the people in those schools respected Lyle. I suspect Lyle didn't interfere with their operation very much. The School of Public Health, School of Nursing, when they needed support or needed something or they needed the right word at the legislature, Lyle would pull one of his, oh, scuffing-shoes-in-the-dirt kind of approaches, the kind of, oh, yes, I'm just a simple country boy type of person and get the job done. He had a way about him that was very interesting for a neurosurgeon. He was very unprepossessing, very powerful. I think when he spoke—various things like the nurses would need some big macro thing done—he could probably pull it off for them. In the meantime, he didn't operate their schools. When Neal [Gault] was head of the Medical School, I think Lyle didn't bug him about how the school was

running or whatever. He never mentioned it to me that he was being beset with problems with Lyle. From my very, very removed direction, that's my best assessment of how that worked at that time.

Besides, what was Lyle doing in those days? Those were the days when the buildings were being built. So they were consumed with the idea of building the most expensive building the State of Minnesota had ever built at that time, which was the PWB [Phillips-Wangensteen Building]. Lyle went to Jay Phillips and got money and in return Phillips got his name on the building. By the way, it was remarked later on that if Jay Phillips had been at Harvard, he would have never gotten his name on a building for a million dollars.

[chuckles]

RM: Have you heard that?

DT: I haven't, but that makes sense.

RM: He did establish the Phillips chair of surgery, also, so it isn't that Jay Phillips hasn't done a lot for the Medical School. Lyle, I think, may not have made a hard enough bargain. He probably could have gotten more for that kind of recognition. But, anyway, *sic transit gloria*. It's now known as PWB.

[laughter]

RM: Sorry.

I think that's probably the way he operated. He was a very powerful person, a person you wouldn't want to cross, but was unprepossessing in the sense of looming over you, not trying to show it. Is that kind of what you're getting from other people?

DT: Yes, that's pretty consistent. I think Doctor Cavert had said that everybody liked him. He was a likable guy...

RM: Yes.

DT: so he fit well into the position.

RM: When he retired as the vice president, all of his people gave him a little something, and they were all there with their pictures and all smiling. The head of the School of Public Health [Lee Stauffer] and the head of Nursing [Ellen Fahy] and others, they were all personal friends with him. I suspect they wouldn't have been that if he had been fussing around with their units, so that's why I concluded that.

Besides, he just had this miniscule staff. They were down in this little postage stamp of an office right off the lobby there. I think the School of Public Health is in that area now.

He just had a small office there with three people: the honorable Lieutenant Preston, and Lyle, and the secretary, who is now Charl...

DT: Charl [Charlene Thoenke].

RM: Yes.

DT: She just retired.

RM: Oh, did she?

DT: In May, she retired.

[laughter]

RM: You better do these fast! They're going fast.

DT: I thought I would talk to her because she actually said she'd been around a long time.

RM: Oh, yes. Well, of course.

Will you see Cherie Perlmutter?

DT: Yes, I do plan to. I need to do a bit more research before I connect with her, but, yes, I definitely want to talk to her.

RM: One time when we had a site visit, I ran many for the Medical School in 1980, 1987, 1994. I ran three, maybe four. The one that was in the 1980s, she was the vice president. She wasn't acting; I don't think she was acting. I think she was the vice president. Cherie does not have a doctorate.

The chairman of the site visitors remarked to me later—I knew him—that he was just totally impressed with her, totally impressed with her for a woman without a formal academic background. She knew where all the bodies were buried...

DT: [chuckles]

RM: ...where everything was. Then she knew administration and she knew how to speak that lingo. She impressed the chairman of the site visitors who remarked later, "She was a *very* impressive person." I suppose they said that because they knew that she wasn't a president of the University or had a doctorate. Maybe that prompted them to say that. She certainly carried her own. I don't think she was acting v.p. I think she was vice president or, maybe she was an interim.

DT: I'll be able to find that out.

RM: There have been quite a number of them that have come and gone. However, Frank is holding on.

[laughter]

DT: Well, this had been wonderful. Now, I have many more questions that I'd like to follow up on in the spring.

RM: Okay.

DT: Obviously, we've just focused mostly on the 1960s and some in the 1970s, but you've been in the administration for a lot longer, so I hope I can talk to you...

RM: Oh, I love to talk about it, of course. I hope that I haven't bored you.

DT: Oh, no, this had been fantastic. Great. This is really great information. Thank you.

RM: Okay. Good enough.

[End of the interview]

Transcribed by Beverly Hermes

**H**ermes Transcribing & Research Service

12617 Fairgreen Avenue, St. Paul, Minnesota, 55124 - 952-953-0730 [bhermes1@aol.com](mailto:bhermes1@aol.com)