James Boulger, Ph.D.
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

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

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

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

Biographical Sketch

James Boulger received his BA in Psychology from the College of St. Thomas in St. Paul, MN in 1963 and his PhD in Psychology from the University of Minnesota-Twin Cities in 1968. In 1969, Boulger joined the faculty of the Department of Psychiatry at the Medical College of Ohio at Toledo, first as an instructor and then as an assistant professor. From 1972 to 1974, he served as assistant dean of student affairs at the Medical College of Ohio at Toledo. In 1974, Boulger moved to the University of Minnesota-Duluth (UM-D) Medical School. From 1974 to 1978 he was associate professor of Behavioral Sciences and Psychology, from 1978 associate professor of Behavioral Sciences and Clinical Sciences, and since 2005 professor of Behavioral Sciences and Family Medicine. In 1974, Boulger was appointed associate dean of curricular affairs of UM-D Medical School, a position he held until 1976, when he was appointed associate dean of curricular and student affairs. From 1977 to 1979, he was associate dean of admission and student affairs; from 1979 to 1983, associate dean for administration, admissions and student affairs; from 1983 to 1988, associate dean for administration and student affairs; and from 1988 to 1990, associate dean for student affairs and alumni relations. Boulger has served as acting or interim dean of the UM-D Medical School on three occasions: acting dean from July through September 1975; acting dean from July 1980 through January 1, 1982; and interim dean from October 1, 1987 through September 30, 1988. From 1988 to 1990, Boulger was interim director of the Native Americans into Medicine program at UM-D Medical School. Since 1975, Boulger has served as director of UM-D Medical School's Family Medicine Preceptorship, and since 1993 he has directed both the Basic Science Faculty Family Practice Preceptorship and the Medical Student Research Assistantship Program in Family Medicine. Since 1990, he has served as director of alumni relations at the Medical School. In 2000, Boulger was appointed director of UM-D Medical School's Center for Rural Mental Health Studies, a position he continues to hold. And from 2007 to 2012, Boulger served as head of UM-D Medical School's Department of Behavioral Sciences.

Interview Abstract

James Boulger begins the interview discussing his educational background. He briefly discusses his first academic job at the new Medical College of Ohio at Toledo in the late 1960s and his decision to move to the University of Minnesota-Duluth (UM-D) Medical School in the early 1970s. Boulger describes the work done to get the school ready for the first class of students; the experiences of the charter class; and the experiences of the faculty—including the challenges they encountered—running the medical school in its first few years. He discusses the different expectations and priorities of the UM-Twin Cities Medical School and its faculty compared to the expectations and priorities of the UM-D Medical School and the state's rural clinicians and legislators. Boulger discusses the move on the UM-D campus to unionize the faculty; the establishment of the first curriculum and the Department of Family Medicine at UM-D Medical School; various UM-D Medical School deans; the decision by the UM-D Medical School to use community physicians as clinical faculty; and the responsibility of a land-grant university to the people of Minnesota. Next, Boulger discusses Robert Carter's departure as first

dean of UM-D Medical School, the appointment of Arthur Aufderheide as interim dean, John LaBree as dean, and Boulger's term as interim dean. Boulger describes the strategies that were used to recruit students committed to family medicine and rural practice and the strategies used to recruit Native American students to UM-D Medical School; and reflects on the changes in family medicine in rural and urban practice settings over the past forty years, particularly in terms of what procedures family medicine physicians are performing. Boulger goes on to discuss the relationship between UM-D Medical School and the Duluth area hospitals—Miller-Dwan Hospital, Saint Mary's Hospital, and Saint Luke's Hospital—and the establishment of the graduate medical education at these hospitals; the relationship of the medical school to the rest of the UM-D campus; and how the UM-D Medical School faculty balance their teaching, research, and service responsibilities and expectations and whether the balance of those expectations changed once the Duluth and Twin Cities campuses merged. Next Boulger discusses his second two tenures as interim dean. During his second stint, Boulger describes dealing with difficult retrenchments, while during his third stint, he describes trying to marshal support to convert UM-D to a four-year medical school. Boulger next discusses the establishment of the Center for Rural Mental Health Studies, telemental health, and telemedicine; and the Rural Medical Scholars Program.

Interview with Doctor James G. Boulger

Interviewed by Doctor Dominique Tobbell, Oral Historian

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

Interviewed in Doctor Tobbell's Office 510-A Diehl Hall, University of Minnesota Campus

Interviewed on July 28, 2015

James Boulger - JB
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor James Boulger. It's July 28, 2015. We're in my office at 510-A Diehl Hall.

Thank you for coming to meet with me today.

JB: You're very welcome. I'm happy to do it.

DT: To get us started, perhaps you could tell me something about your educational background.

JB: I was born and grew up down here in Minneapolis. I went through grade school and high school. I went to DeLaSalle High School on Nicollet Island. I went from there to what was then the College of Saint Thomas, which was, at that time, a small liberal arts college in Saint Paul. It has now grown to be kind of a mega university kind of thing with a multi campus and all that. From there, I headed over to the University of Minnesota to pursue studies at the graduate level in psychology. I spent time here until I was granted the Ph.D. in psychology in 1969.

From that point, I jumped to Toledo, Ohio, for my first position out of graduate school. They were beginning a new medical school in Toledo, Ohio, and I thought that would be an exciting new venture to begin at an educational institution without any traditions to build on, but, also, none to hamper growth. It was a time when there was a lot of churning around in medical education. There was a lot of consternation about health manpower, much like there is still today. There was a lot of politics involved in Ohio. Ohio State [University] and Case Western Reserve [University] had had the market for

decades and decades to themselves. Then, all of a sudden, a few upstart campuses came along like the one at Toledo that I joined. I think I was the twelfth faculty hired there. Another new one started about the same time over in the Dayton-Akron area of Ohio [Wright State University School of Medicine], so, suddenly, there was a lot of fighting for political dollars and real dollars, at that point, too. I spent five years there developing curricula and trying to establish a small amount of research. I ended up getting into some administrative things. I was the assistant dean for student evaluation, promotions, student affairs kind of stuff there.

I was not discontented there, but my family didn't particularly like living in Toledo, Ohio, as much as they wanted to live back here in Minnesota. My wife is from Excelsior, just west of the Cities here. All of her family was here, brothers, sisters, everybody, as are mine. So the draw back to Minnesota was there. I found out that there was a new medical school starting in Duluth. More on a lark than anything else, I contacted [Dennis] Denny Brissett, who was the chair of the Behavioral Sciences department at that time and said, "Well, I got some experience in medical education down here in Ohio. I'm from Minnesota. Anything open?" They were in the process of hiring, at that time. There are a lot of stories there. I was successful in obtaining a position. I thought I was applying as a faculty member.

The charter dean, [Robert E.] Bob Carter, called after the first visit and said that they wanted to have a relatively immediate second visit and, this time, have me stop off in Minneapolis on the way up to Duluth and see, then Vice President Lyle French and then Dean Neal Gault, and Associate Dean [Robert J.] McCollister, who was the curriculum dean down here, and Associate Dean for Student Affairs [W. Albert] Al Sullivan, "Sully," and I think I met with the Assistant Dean Pearl Rosenberg, at that time, as well. I said, "Why? I just want to be a faculty person and enjoy the wonderful life of a faculty." "Well, we have some administrative things. Blah, blah, blah, blah." I said, "Sure." I came back for a second visit and stopped here in Minneapolis, saw those people, nice people, good people. I got into a little bit of a discussion with Vice President French. The curriculum in Ohio was a three-year, fully integrated curriculum and he thought that was a dumb model.

DT: [chuckles]

JB: He had, I think, gone through med school in three years at the beginning of World War II when they really accelerated people into the military by cranking them through med school faster and faster. He remembered that that wasn't so good. There were no breaks. It really drove a lot of people kind of up the wall, very, very grueling. So he wasn't too sure that was a good model. So we got into a good discussion of what makes a good student, of what makes a good faculty, all of that. It was a good discussion. I figured that probably…you don't start with an argument with the vice president to get a job. I didn't really care because I wasn't being forced to move other than family pressure, which I felt. That wasn't a bad thing.

I went back up to Duluth, got interviewed by everybody in Duluth, literally every faculty person. I went back to Toledo and told my wife, "I don't think that one is going to work." She said, "What happened?" I described some of the things that happened on the visit. She said, "Well, wait and see." I got a call from Doctor Carter a couple days later offering the position. I said, "Are you sure you know what you're getting into here?" I had told them that I had had a little bit of an animated discussion with the vice president. He said, "Yes, but that was an honest one. It's okay. He told me about it." I said, "Okay, fine." He offered me the position as associate dean for curriculum and associate professor, all that kind of stuff. I said, "I don't really care about tenure, so that's not part of the package." He said, "Okay, no problem." I said, "I do care that it's a good salary and all that." I think, at that time, he offered $21,000, which sounds so small today, but, at that time, it was okay. Later, when I got to Duluth and got my first paycheck, it wasn't' $21,000. It was less than that, but he made sure I was tenured. I said, "I didn't want the tenure. I don't care about tenure. I'd rather work on a handshake and not indebt anybody." Anyway, it all worked out.

I was onboard about a week and he said, "By the way, we've got a site visit coming up for accreditation fairly quickly." At that time, the school was in session but they had provisional accreditation, which you get at the beginning. Then, once your first class has made it through, you can apply for and receive full accreditation. For Duluth, since it was officially going to be accredited as a two-year program—probably the last one that was—it hinged on the satisfactory completion of two years of that first class. That was coming up. The pre-visit before accreditation was a couple months before which they finished by the time I got there and got my feet on the ground. It was like two months off. I said, "Okay! Let's see the preliminary, the first accreditation visits." There were some rocky roads along the way that he hadn't bothered to mention when he was recruiting me. I had been through a number of accrediting things down in Ohio, helped out with that. So I said, "Okay, here's a challenge. Let's do it." I started preparing materials. I said, "Let's start with the curriculum. Give me the curriculum." He said, "What do you mean the curriculum?"

DT: [laughter]

JB: This sounds terrible, but they had been so involved with getting up to speed. The hiring process for him was relatively quick. He had assembled faculty really fast. They were much more concerned about getting the right people together than exactly what it might look like on paper. There was the assumption that if you hire somebody in physiology, they probably know how to teach physiology to med students. At that point, there were no teaching objectives per session or even per course. As it turned out, there were no courses really established to speak of through University channels or anything else, no campus approval. David [A.] Vose—you might have seen the interviews with him—talks a little bit about that. It was interesting having the Med School come to campus because they ran their own way. We did run our own way. Doctor Vose was one of the first people that I made contact with on the regular UM-D campus. He was the chief academic officer. I went to him and I said, "How are we registering these folks?" He said, "You know, I don't know. There are no real courses on the books." Quickly, I

think within ten days, I had the full two years of the curriculum established officially on the books with credits and course descriptions and all that stuff. It's not that hard [whispered]. But no one had gotten to it yet. That was one of the beefs that the accreditors had when they came in, "Show us your curriculum." Well, we know what we're doing. So that was the first big task.

Then, the organization was odd. There were no departments. It was just the campus and the Medical School. Budgetary controls totally in Dave Carter's office and I mean totally. If you wanted paperclips, you had to go see the dean. There was no departmental establishment of accounts or anything else. That was one of the things that got changed pretty quickly, as soon as Bob stepped down. We organized into what we thought were more true departments at that point. So we got a curriculum established. We sort of started moving toward departments.

The accreditors came in. They had some big concerns about training our medical students out in the community with community physicians as faculty. People had not been doing that up until that point. We showed what the objectives would be. Many of them were experiential. Others were more academic. The objectives looked okay on paper. They talked to the students. The students said, "This is what we're doing. This is what we're getting. This is what we're learning." "Uhhhhh…it's probably worth a shot. We're going to come back again in a few years anyway." So we got through the accreditation fine. We got full accreditation.

The first class then transferred down to the Twin Cities. It was a small handful even back then went to the Rural Physicians Associate [Program – RPAP], the third-year program. I think there were probably four or five in the class that did that. There were only twenty-four in the first class. Twenty-three successfully completed the program, passed boards, and transferred. One of them was not able to get through boards on the first try nor on the second, and she chose not to continue.

It was an interesting first-year group. There was a set of identical twins who I still cannot tell apart, Barbara and Betty Bowers. I still don't know which one is which. The only way I can tell them apart is if I see one in Oklahoma, I know that's Betty. Barb works down here in the Twin Cities. When you see them together, you cannot tell them apart. We had a nun. We had two Native American students, which was really unusual, I think. Up until 1972 in the history of the United States, there had been—it's hard to tell—six or seven Native American physicians. We started with two out of the twenty-four in the class, both of whom were fine students. One [Edward LaDue] went into family medicine and went back to practice over in Mahnomen, Minnesota. He started on the White Earth [Reservation]. He moved off the res [reservation], because he couldn't stand the IHS [Indian Health Service] and all the bureaucracy involved. He just wanted to take care of patients. He set up shop in kind of a trailer and had a very casual, informal family practice. [chuckles] The community loved him. The other Native American student did just fine. He did his residency in internal medicine here at the U and headed back up to Duluth. He turned into a guy named Alan [M.] Johns, who was our recent intern dean before Doctor Paula [M. Termuhlen] who is our current regional campus dean. Those

guys both did well. Everybody really did quite well when they transferred down. They completed their degrees on time and matched into decent programs. So it was successful.

Their careers, from that crew, as I look at them now…they did very well. Good practitioners. A couple of them went academic. John Huber, surgery, authored a textbook on surgery that was fairly well received and adopted by a number of other medical schools. Roger [K.] Waage, who just retired from the residency in Duluth, had been the program director of that program for a number of years, been on the faculty for a number of years before that and been in practice before that even. Alan Johns has done quite well. Just this last week, he was appointed to the position of associate dean for education, curriculum, and technology, some fuzzy title. I don't know exactly. He's really a nice man. So the first class did very, very well. I think had that not happened… I don't even want to think about what would have happened next. We were banking a lot on their success.

Because of the accreditation and provisional accreditation timing, and all that kind of thing… You cannot accept a student into your medical school educational program until you get that provisional accreditation. So we we're trying to get open in September of 1972 and we didn't get the provisional accreditation until August 1, 1972. Well, who's left in the pool? That's who you start with. Many of them had been accepted elsewhere. Then, they get a letter from us. They pulled out of those other places to be pioneers, kind of. Some had not been accepted elsewhere but were on waiting lists. So, bam, we come along. Hey, great. Fine. That starts you off at a real disadvantage, because the poor students don't even know they're in. They know that they *might* be in *if* you get accredited. It was interesting.

They got through the first two years fine. There were, I think, three who didn't make it through boards on the first try. Two made it immediately thereafter. One never did. That slowed down a couple of them for a little bit but not much. The clerkship years are flexible enough to take a little bit of bending. They pretty much all graduated on time. The second-year class, hardly anybody remembers because everybody was paying attention to the charter class, so it's like the lost child. Poor devils. It was chock full of really good people, again…two Native American students, again, neither one of whom made it, unfortunately.

At that time, the faculty took our mission that was set by the Legislature, Rural Family Medicine, and added that third mission to it, Native American Health with the recognition that somebody had to do something. We're new. Maybe we can get away with some stuff that other schools have a hard time with. They might be too established in their mission's process. We were more risk takers. It was a risk being there, for goodness sake.

There were, literally, times… I remember one time when one of the department heads was telling a newly-hired faculty person who'd been onboard a month only… I ran into him in the hallway and they were chatting. The department head was saying, "We might not get paid this week." This young faculty just kind of was melting. That was one of

the times I was acting dean. I overhead and I just couldn't let that go. I stepped in and I said, "I think there's a difference of opinion here. This chairman has that opinion. I am not of that opinion." You're in a tough spot, because you're department head and the dean. Who are you doing to believe? I said, "I'll tell you what. I'll put a hundred bucks down right now that we get paid and I want him to put a hundred bucks down, too. If we get paid, I keep both hundreds."

DT: [chuckles]

JB: "If we don't get paid, he's going to need that two hundred. He's going to have to go find a job, but I expect him to share that with you." I tried to make a little bit light of it. Well, we got paid, obviously. It was a little dicey there for a while.

I think there was a spirit among that first faculty group that we were fighting odds to stay alive, to stay confident, to stay accredited, to make sure the students were well trained so when they did transfer down to the Cities or to RPAP that they hit the ground running and they could handle things well. There was a *great* spirit of camaraderie among the faculty. There were times when we would create enemies out of, I think, fabric, simply to pull together a little bit more. "All those people in Minneapolis don't understand us. We've got to make sure we do"…that kind of thing. A lot of it was rah-rah pep talking more than anything. I think some people actually started to believe that stuff.

The reception our students got when they transferred down here… They ran into a *topnotch* faculty, an *excellent* medical school. It was way different. We were teeny; this is big. So there was some adaptation to be made, but they hit the ground running. They were able to handle things well clinically. They did at least as well as their Minneapolis counterparts. So I think that kind of thing just kind of feeds on itself. Then, the word gets back to the class behind them, "Hey, we're doing okay." "You guys are getting a decent curriculum, blah, blah, blah, blah." We have learned a few things along the way like study your butt off for boards."

DT: [chuckles]

JB: For the second, third, fourth, fifth, and sixth classes in Duluth, every student passed national boards on first try and *nobody* in the country can touch that record. Okay? The entire class passed. That's really rare. Most schools will never have that happen once. Then, the pressure came on the students. "I don't want to be the one to ruin the record."

[chuckles]

JB: So I was praying as Student Affairs dean at that time that at least two of them would go down. If just one did, it was going to be a disaster. Sure enough, two of them… We had a bad year or they had a bad day, something like that and we had to hear, "Oh, my god! A couple students failed." Then, they retook them and passed them.

It was small. The smallness was, I think, a real benefit as well as a disadvantage. You've only got so much faculty talent in fifteen, twenty people. So we were borrowing on some of the talent from down here. A.B. Baker was a world famous neurologist. He probably made this Department of Neurology down here world famous. He would come up and give lectures to Duluth students, because he wanted them all prepared in neurology. He just put his money on the mark and said, "I'll be up," and he would come up. He'd come up Friday evening and we'd have Saturday morning classes with A.B. Baker from eight till noon. Then, he'd hop in his car and drive home. I was lucky since I was running the curriculum and got to know a lot of these folks. He was a delightful guy. He grew up *Nordeast* Minneapolis. He's kind of a crusty guy but brilliant in his way, brilliant in neurology worldwide. You know this. He would come up. He was a tremendously demonstrative teacher so the students, even on Saturday morning, were pretty much awake. They enjoyed it a great deal and they learned a lot of neurology. I guess folks down here were teaching neurology. They certainly got the cream of the crop. So that helps, too. So we had some really good help from everybody down here along the way.

It has not been without friction, but it's generally been good. Some people down here thought that was a mistake to start a campus up there, that those were dollars that should have come directly to the Med School here and we would increase the class size down here. We'll push rural. We'll push family medicine more. We'll do this and we'll do that. You wrote the article ["Plow, Town, and Gown: The Politics of Family Practice in 1960s' America"] about the growth of family medicine and the push from the family docs about the University. Some of those letters back and forth were [whistle] pretty hot.

DT: Yes.

JB: Pretty hot back then. That's good stuff. I like that. I think they were making some valid points. I remember very well probably twenty-five years ago… Doctor [Benjamin P.] Ben Owens is an icon in family medicine in Hibbing, Minnesota. He, basically, assisted in the births of half the town, at least. Kevin McHale [retired professional Celtics basketball player and, later, general manager for the Timberwolves was born in Hibbing] and all of Kevin McHale's kids, the whole family up there… He took care of that whole community. Every sporting event, he was at for the high school. He married medicine, never had a family. Doctor Owens called John [S.] Najarian, who was chair of Surgery down here at the time, and said, "Doctor Najarian, this is Doctor Owens up in Hibbing, Minnesota. We need a surgeon. We want you to train a surgeon for Hibbing." According to Doctor Owens, Doctor Najarian said, "We don't train surgeons for Hibbing. We train department heads for other medical schools. That's what we're here for." Whoa! Okay, baby.

DT: [chuckles]

JB: I don't know if you ever met John. He's flamboyant, remarkably able. I found him likable, you know. But, "Oh, no. We train department heads." I heard him say things similar to that before, so I've kind of given that some credibility. I said, "What are you going to do about that, Doctor Owens?" He said, "I don't know. That's why I'm calling

you, Boulger. Train me a surgeon. Get me a surgeon up here in Hibbing." I said, "This is still the United States and we can't just enslave people, Ben."

[laughter]

JB: He was a Ranger [Minnesota Iron Range native]. He thought you could do that stuff. He was an interesting dude. He passed away about a year and a half ago [Doctor Owens died on January 21, 2014]. He was an icon up there.

It was people like that who were pushing all over the state, as you saw when you researched for that article. These are people like Lyle Munneke out in Willmar [Minnesota] who were saying, "The University has got to deliver for us. They didn't believe this campus would do it. So they went to the Legislature. The University, I think wisely, said, "We will create some programs that will assist with that" and that's when RPAP was born. That's been a *fantastic* program for the state, just fantastic. In the same session, they said, "But we're not sure that's going to take care of everything, so we'll do this thing up at Duluth, too, for a while, and see if that works out."

The day we opened was the same day Mayo [Medical School] opened. So we had two very different programs beginning and one super good traditional program in place. We were separately accredited. We wanted to be cooperative but independent. I think that served us well for those years. I don't know if it would have been better or worse… It's hard to tell. Some things probably would have better, some things probably would have been worse.

Back in those days, also, was the move on the UM-D campus to unionize the faculty. The UM-D campus went union. The Medical School faculty did not want to be part of the union. We did not think that was appropriate for faculty. So we sued both the Board of Regents and the state labor board, basically, saying that our conditions of employment were sufficiently different than the rest of the campus, which was not a research oriented campus at that time at all, and the expectation for promotion and tenure were markedly different, that we were sufficiently different that we should not be included in the bargaining unit, and we won, which didn't win us friends here, and it didn't win us friends there. Instead, we're this rammy group that has to do their own and all that stuff. The interviews with [Wilmar L.] Will Salo—if you've had a chance to read or watch those—he was in the Department of Biochemistry. He came out of the Department of Chemistry at UM-D. He knew all those people well, liked them all. They all got along well. The chemists on the campus were really pro union. The biochemists in the Med School were pretty much pro union, but the rest of the people in the Med School were not pro union. We had some *fascinating* faculty meetings talking about what it's like to be a faculty member and what does the tenure code say and mean in this wonderful year of 1975, 1976, 1977, and all that stuff. What is academic freedom? How much do we want to give in terms of administrative authority, clout, bargaining, things like that? How much do we want to be independent and be kind of the protypic [prototypical] faculty person who does research, who does teaching, who does service but who is not enslaved to a union? So there was some good head knocking on that one. It went to a vote. Then,

we had to go to court. Actually, the arbiter said, "Yes, you're sufficiently different. You're no longer a bargaining unit." The rest of the U, other than Crookston and the faculty in Duluth, those folks, don't have any representation in University governance, because they're union. I think that's a real drawback for UM-D and Crookston. But that's my opinion. They don't think so. Financially, I think the faculty in the bargaining units have done better than we have, frankly. They've had guaranteed increases every year. There were a number of years when Medical School faculty in Duluth got no raises whatsoever. I can think of a period of time, an eight-year period, where we had no raises five of the eight years. That's the way it worked. I think we were economically disadvantaged by that decision. We still felt okay that we were still independent, full faculty, and all that. We had our good colleagues down here. This campus decided not to go union, too. So we were in pretty good company.

DT: When you said that there was antagonism on the Twin Cities campus because of your stance against the union, the Medical School wasn't antagonistic to your position?

JB: No. No. The Med School faculty down here could care less. I don't even know if they knew what was going on.

DT: So it was the rest of the faculty, the non medical campus?

JB: Yes. We're kind of an island within UM-D.

Very early on, when I was serving in the dean's office… This came up sort of when I was acting dean and other times with the next dean, John LaBree, who came out of the Twin Cities. He had been the residency program director for family medicine at Saint Mary's Hospital right across the [Mississippi] River, which is now Fairview [Hospital]. He was also one of the founders of the Saint Louis Park Medical Group and had done very well with that *and* he was a classmate of a guy named Lyle French who was vice president. So he was our second dean. He is a wonderful guy. Everybody loved John, because he would never say, "No." I was the associate dean. He would have a bargaining session with one of the department heads and when he'd finish up, he come in and say, "Okay, we've got to do this and this." I said, "John, we don't have any money." "We've got to do it. I told them we'd do it. Make that happen." I said, "Really? [unclear]." So we would have some interesting times in discussion. A wonderfully nice guy. Everybody loved him, not necessarily too academic but I think a good friendly leader for the faculty up in Duluth. He was a good guy. It was during his term that he turfed a lot of the administrative stuff to me.

There was one period of time when I was acting dean the second time where there was a big retrenchment at the U and the campus' proposal to handle the retrenchment for the campus was to cut the Medical School.

[chuckles]

JB: Well, we didn't think that was a very good solution. I had a number of meetings with the campus administration saying that this is not appropriate and the Legislative authority and tried everything. It finally got to the point where I said, "We are not your property. We report to Vice President Lyle French. We do not report to you as campus provost. We're interlopers in your land. We do not report to you. You do not control our budget." That had been the budgetary path, directly from health sciences to us, not the Med School to us, because we were separately accredited. He said, "We are going to handle this in the following way. The president of the University will make that decision. So we're going to have a little meeting." I said, "Oh, good, just what I like, little meetings." Provost [Robert L.] Bob Heller was an intimate player in all of this, because he really was pro the Med School and getting it going and all that. He was not against the Med School. But he was in a position where that campus needed protection from a huge retrenchment and we were a good sacrificial animal. I might have done the same thing; I don't know. So we set up a meeting. It was Lyle French and [C.] Peter Magrath and Bob Heller and I. Bob and I headed down to the Cities here to meet and we had this meeting in the president's office. He made the case that we were on the campus and we want to have good relationships and we have faculty there who teach some of our students on the undergraduate level, so we want to have this [unclear] and blah, blah, blah. So they should be subject to retrenchment. The president looked at me and he said, "What do you think?" I said, "Well, I think we have to follow the legislative mandate. The Legislature was pretty clear in establishing us not as a unit of UM-D but as a unit of the University with a specific purpose and goal. It was campus directed and all that stuff." The president looked at Lyle French and said, "Lyle, what do you think?" "There's no question. They report to me." Peter said, "Okay! That's it. Thank you for the meeting." Okay.

DT: [chuckles]

JB: Bob and I headed back to Duluth. We didn't hate each other or anything. I said, "Bob, I understand you're in a real bind. But I can't let this program get killed off to save your programs." He said, "I understand what you're saying. I don't think you're right. I don't agree with you, but that's okay." We were never close friends. I don't mean to say that but we were never enemies either. He was just doing what he had to do. I understood it. The faculty, on the other hand, didn't understand all this stuff sometimes. We've got faculty still who think that was a real mistake. We should have sided with the UM-D campus. Literally, their plan for retrenchment was to close the Medical School and close Dental Hygiene. Boom! Dental Hygiene didn't make it and a lot of their other programs got retrenched, as well, so it was a very, very tough time. I was scared to death. I had no idea if I was going to go back and have a job. I had no idea what Lyle was going to say. I did not prep him or anything. I couldn't have prepped him if I'd wanted to. You didn't change Lyle's mind very much.

He was a good leader, an excellent leader. He had *tremendous* credibility with the Legislature. He would go over there—he grew up in Northeast Minneapolis—and put on this good-old-boy-aw-shucks-I'm-just-like-you-guys kind of thing. He had so much credibility with the Legislature. It was just scary. If he came in, whatever he said was

gold. Presidents of the University didn't have that. Lyle had that. He was really good. [Stanley B.] Stan Kegler was the big University guy who was the legislative liaison from the president's office at that time. He was v.p. for some fancy thing; I don't know. Kegler had really good relationships with the legislators, too. He would like hang out over there a lot and became very friendly with a lot of the legislators. Lyle was just an easy-going guy that everybody kind of liked. Some just trusted him. So that was a great combo for the U, great for health sciences, and great for the University in general. Those were good years for the U, even in spite of the fact of retrenchment and things like that. Those were economic necessities of the times. So you have to make it through them and try and grow again.

Enough of that.

DT: [chuckles]

JB: There's lots of stuff.

DT: Yes. That's great. That's a lot of information.

I want to go back to some things and follow up.

JB: Sure.

DT: Was the name of the Toledo school the University of Toledo College of Medicine?

JB: It was the Medical College of Ohio at Toledo. It is now part of the University of Toledo. At that time, it was a separately accredited, freestanding, non-university affiliated, a growing-up-in-the-middle-of-the-cornfield-in-Ohio Medical School. Honest to god, it was weird.

[chuckles]

JB: So the Medical College of Ohio at Toledo.

DT: Okay. I was looking online and that was the only one I could find in Toledo.

JB: Yes. It is now the University of Toledo.

DT: I couldn't find anything about its history.

Let's see. A lot of this stuff you actually already brought up. I'm glad.

Going back to the discussion about the curriculum that you set up when you…

JB: That the faculty set up. I tried to facilitate it. It wasn't my curriculum. There were things I had to say, but…

DT: Sure. The curriculum that the faculty set up and that you kind of coordinated when you first got to UM-D, was the faculty modeling that? Were there other examples that they were able to draw from?

JB: Not much. The curriculum started out as a departmentally oriented curriculum for most large chunks. There was a number of courses in physiology taught by physiologists, so it was standard old by the book med school physiology, med school anatomy, med school microbiology, med school pharmacology, biochemistry taught by those departments. Then, there were some bridging courses that were different than others. Most medical students at that time in their first year never saw patients. They never really had any clinical experiences. Some medical schools went all the way through the first two years, so it was pretty much lecture and lab bound only. Case Western Reserve had in the mid 1950s done some curriculum innovations, things where they tried to do a little bit of integrational and tried to thread some clinical things through, but not many people were doing that. It was still pretty much the Flexnerian "two plus two" model. Where I think we made some changes that were important were in honoring and respecting family medicine as a discipline and not putting it down as has happened in some places, and saying that this is our mission. This is our goal and we actually mean this. What we're going to do is we're going to put our students out there and observe family medicine in practice and set up a preceptorship set of experiences for them. It will not be content oriented but will be process oriented and will be professionally oriented. So it will not be like the standard old course of family medicine by the book. It will be how's family medicine going to be practiced, things like that. It will allow patient contact from the get-go.

That means we're going to have to introduce the students to clinical skills earlier. That, then, becomes another threaded course through. Clinical skills has different names at different times in the curriculum. You don't just turn med students or anybody lose in a doc's office with no training. We want them to be comfortable. So we said, "What skills can we build in fairly early?" Most people can talk to each other and communicate a bit, so we started with communication skills. How do you take a good medical history? How do you put that in the context of the practice of medicine, but, also, in the life of the patient? How do you marry the patient and the doctor and emphasize the whole person as opposed to the physiology of the person, the anatomy of the person? How can we tie that together? So it was kind of a precursor to some of our later curricula efforts which became more organ system based and messed the disciplines, pulling from the departments into courses, rather than let the departments run all the courses. Either way works in my opinion. True integration happens in the mind of the student not in the mind of the faculty. So we did some introduction to gross anatomy with our community surgeons. So when we had gross lab, the anatomists would be in there. There would usually be two or three community surgeons come in for the afternoon. They'd walk around and say, "Hey, look, here's the spleen. I took one of these out last week. Boy, you should have seen that one." They talked a little bit about pathophysiology. It made anatomy a little bit more living for the students. Even the straight departmental courses, the departments and the faculty within those basic sciences would have relationships with

community colleagues so that when they were teaching pharmacology, they would have the oncologists come in, as well, so they could talk about the science and the chemistry behind the pharmacology, but, also, talk about this is the new chemo… Well, forty years ago, it was a lot different than it is now. We'd try to establish and I did establish this as part of the curriculum.

A Department of Clinical Sciences was a blah term, but nobody can argue against it either.

DT: [chuckles]

JB: Yes, we're all clinicians. I guess I'll buy that. If I would have said "Department of Family Medicine" at that time, it would have been tougher.

So we started by calling it Clinical Sciences and I created section heads again—medicine, peds [pediatrics], psych [psychiatry], surg [surgery], OB [obstetrics], things like that—from the community. We would take a community surgeon and say, "You're going to be section chief for our curriculum in surgery and we want you to work with our basic science faculty so that when the anatomists are talking about this is your clinical specialty or you get one of your colleagues, an orthopedist or urologist, you line those folks up to come in and work with our faculty. So it was a totally community-based model. We gave them $10,000 a year, each of these guys. I had to fight like hell to get it. "We can't pay our community people." Well, they're our faculty. They're not our community. People are our faculty. We came up with the magisterial sum of - if we had a neurosurgeon come in for an hour, we'd give him twenty-five bucks. Wow!

DT: [chuckles]

JB: The only people we would not pay were the family doctors. We said to the family doctors, "This is your town. This is your school. This is what we're all about. We expect in-kind service from you," and they delivered anything we wanted. It works.

The section chiefs lasted until [Ronald D.] Ron Franks was dean. We had gone through Carter, LaBree, and Paul Royce.

Paul Royce was in there for a five-year period. He's an M.D., Ph.D. endocrinology guy, a brilliant fellow. I really liked him a lot. He was honest as the day is long. Faculty just didn't get him at all. He was too cerebral. He would walk down the halls thinking and he'd be engrossed in his thoughts and he'd kind of walk by people. They thought he was ignoring them. I said, "No, he's just cerebral as hell." He had a good sense of humor but they didn't get to know him. I was working with him every day, so I got to know him a lot better.

After him came Ron Franks. I said to Ron, "The clinical science is the same. It works okay and we've got a department head, [Gerald Eugene] Gene Cotton." Gene was an endocrinologist. He'd been there for numerous years, fifteen plus years. He was kind of

a familiar face to these various clinical chiefs in the community. I was still having something to do with curriculum, so I would work with Doctor Cotton on that, as well. Because we were using all the family docs in the community, you can't get to know the family docs without knowing a lot of the others, too. So I got to know a lot of the docs downtown. We did a lot of just personal stuff, stopping by the office. "I know we have to talk about curriculum, but I don't want you to have to come all the way out here." So we'd go to them. It worked better that way. That lasted until Ron came.

We said, "You know, this *is* a family medicine oriented medical school. We should have a department of family medicine." He said, "Well, yes, but how are we going to fund it?" I said, "There are federal funds from HRSA [Health Resources and Services Administration], from HEW, Health, Education, and Welfare at the time, for the establishment of departments of family medicine at medical schools. I think we're well positioned to get one, but what I don't want to do is create a department of family medicine and tell our community to go to hell. What I'd like to do is write a grant to establish a department of family medicine which has put in it sections headed by our community docs that gives us a teaching cadre out here, as well." He said, "I don't think that's going to work." I said, "There's one way to find out." We'll pull together. I think it was student affairs and administration at that time in terms of deans. Administration meant doing what the dean didn't want to do, that kind of thing, kind of like [H.] Mead Cavert down here.

Mead was kind of the power that was the constant down here, a wonderful man. Really. You've interviewed him haven't you?

DT: Yes.

JB: He and June [Mrs. Cavert] are just solid people.

DT: Yes.

JB: He said, "See what you can do." So I came up with an application, all that kind of stuff for funding for a department of family medicine. He took a look at it and he said, "Uhhhh, that doesn't change that much. It gives us some more faculty." I said, "It also puts us on the federal dole. These are dollars that are not from the state. We're going to have to work really hard to keep them in place and replace them. But once you get into that game, you can't give it up. You have to keep hustling." Ron was not exactly a grant writer. The guy before him was not and the guy before him was not. I'd gotten a lot of grants along the way for administrative things and all of that, but not for a department necessarily. He said, "Ah, go for it."

So we got it. I said, "Okay, now we need a department head for Family Medicine." He said, "We've got Gene Cotton." I said, "Gene's an endocrinologist." I had talked to Gene Cotton. I said, "Gene, how long do you want to do this kind of stuff. If we did go with this department thing, would you stay on as the section chief for medicine?" He's

really a good guy. He said, "Sure. I don't care about this. Is it going to get us more faculty?" I said, 'Yes, it will." He said, "Okay."

I said [to Ron], "Now we need a department head for Family Medicine." He said, "Uhhh… I don't think we've got any money appropriated for that." I said, "That's why I got the grant. The grant will pay that for the first six years. That will give you some time to put together a package." He said, "Okay." We've got people in place. We need faculty replacement dollars now for the soft money and make [unclear], blah, blah, blah. So that was the plan. It never did come to fruition because the University changed or something changed in the way that proposals for increased faculty were treated within the Medical School—either that or the various deans had different priorities. We were doing okay with the soft money. As long as we kept getting the soft money, okay, and I kept writing the grants.

So we brought in Byron [J.] Crouse as head of Family Medicine. Byron is currently the associate dean for Rural Education at the University of Wisconsin over at Madison. That's not his exact title. [Correctly, associate dean for Rural and Community Health.] Byron was a Mayo graduate from med school, did his residency in Duluth, practiced over in Spooner, Wisconsin, about forty-five, fifty miles from Duluth, for about four years, five years. At that time, I used him as one of our rural preceptors. I got to know him when he was a resident, a very, very nice man, a good doctor. He went from there to the residency program. He was assistant director down at the residency in Duluth for a couple of years. I said, "Well, Byron is an up and comer and he'd be a good department head." So he was one of the candidates. He got the position. So he came in as the first department head. In fact, he lasted for a number of years.

In the bargain, we started writing a couple more HRSA grants to do more curriculum enhancement in family medicine, things like that. So those all were successfully funded, too. The fuel for the fire was the soft money. That's one of our problems at this very moment is HRSA no longer has those programs. So the grant that I've had for years and years and years is now over and there's no replacement funding in Washington for it. Somebody has got to come up with the money to pay all these faculty we brought in and that's not my problem anymore. Hey! All right! It's nice getting old.

[laughter]

JB: I'm perfectly willing to help, but I just can't handle everything myself. They've got to learn how to do more grant writing.

So that department developed nicely with soft money only. I honestly, to this day, think that there's maybe one and a half faculty positions in the department that are firm, state funding out of the Med School budget in Duluth. The rest is all soft. We don't have a clinic. We don't have any clinical facilities, so we don't have that clinical income stream that is so beneficial. I don't know how much the dean gets out of UM physicians every year, but I know it's millions and millions and millions of dollars that goes to help support the teaching programs. We don't have that funding stream. What we have is

tuition, the state allocation which is not huge, and grants and grant funding for research, training, and everything else. So our full campus operation is probably on the order of $12 or 13 million a year only. It's not very big. My grants had been running about a half million a year. If you take a half a million out of there, that's stings. That, unfortunately, is Doctor Paula Termuhlen's problem, at this point. I think we'll be okay.

I was part of the Governor's Blue Ribbon Commission this year. One of the things we did ask on that was replacement funding for those HRSA dollars. I don't think [Jay] Brooks Jackson has that as a high priority at all. I think he is much more engaged with building the discovery teams. I'm not saying that's bad. I am saying that if there's only so much money going around and we don't get that money, it's got to come from some place else then. I don't know if it will. I suppose it will, but I don't know.

So that's the way that department developed into a Department of Family Medicine. We still had the clinical community chiefs paid from grants, then moving to Gene Cotton. Byron Crouse was on it for a long time. Then, he left to assume a position in Madison with the intent at that time of coming back as dean some day, which has not transpired.

The department, since then, has been run by Doctor Ruth Westra, W-e-s-t-r-a. Ruth is a D.O. [Doctor of Osteopathy], not an M.D., which is a little unusual in a medical school. The D.O.s and M.D.s are coming like this. I look at a D.O. and an M.D. and I really can't tell a heck of a lot of difference. D.O.s are not doing anywhere the amount of manipulation they used to and the M.D.s are starting to get more into alternatives and complementaries than they used to. I think we're talking a horse apiece on this. Still, she is a D.O. When the search committee put together the position description for regional campus dean, it was very clearly stated M.D.s only. That was kind of a slap in the face to her. I don't know if she would have gone for it or wanted it anyway, but that's so old fashioned and I think kind of dumb, but water over the dam.

DT: It also excluded Ph.D.s who might have applied.

JB: Oh, yes. That one I didn't mind so much. Honestly, med schools are very weird for Ph.D.s. The power structure is among the physicians. There's no two ways about it. If the chief of medicine down here gets inflamed about something, that has ramifications. If the chief of one of the basic science departments does, it doesn't have near the input. We're sheltered because we've got basic science only, for the most part, so we think basic sciences are really important. When I say basic, I include behavioral, social, public health, all those kinds of things, non M.D. things. So our faculty is a little bit spoiled. We're not used to M.D.s driving the ship. So when some of the word comes down from the M.D.s from down here, it rankles a little bit because they're just not used to it. Having come out of the med school thing at Toledo, I saw where the power was. It wasn't with me as a non-M.D. Okay, that's fine. I can handle that. I'd rather be judged on competence rather than a degree. I don't care. If I come short, I come short. If I do okay, I do okay. Big deal. That's not the case for everybody. I think we were disadvantaged by having Doctor Rick Ziegler, who is a Ph.D. in micro [biology]. He was dean for five years followed by Gary Davis, who is a Ph.D. in clinical psych, for seven

years. So we had twelve years there where we did not have an M.D. coming down to bargain at the M.D. table. Logically, it shouldn't make any big difference. We're all talking about the education of students but it is a club. Okay? You can sort of be an affiliate member but it's not the same; it's not the same. It's like, okay, you can use the swimming pool on Wednesdays.

[chuckles]

JB: I think that was very frustrating for Rick Ziegler, in particular. I think it was just as frustrating for Gary, but Gary didn't talk as much about it. Rick would come back and just be flaming. [words whispered – unclear] I got over that a long time ago. I said, "If I'm going to be a stranger in a strange land, what can I do with that? I'm not going to be an M.D. I don't want to be an M.D. I'm very happy with who I am. It will cost things. That's okay. What are the bennies [benefits]?" I've had a very, very good life. I like it. It's not been perfect, but it's been really, really good. So…

Paula Termuhlen, our current campus dean is a surgeon. I like her. I like what I've seen so far. She's only been onboard a few months. I haven't had a whole lot of interactions with her, but what I have seen, she's right. She's decisive. She knows what she's all about. When she came in as a candidate, she was challenging, which was unlike a couple of the other candidates who were just coming in saying, "You guys do such a great job of family medicine, blah, blah, blah." True.

DT: [chuckles]

JB: I took that as sort of "Let's sit on our laurels." I think Paula came in and said, "Hey, your laurels are great. Now, get off them. How are we going to survive? Where are we going next? How's the world changing? How's medicine changing? Are we keeping up with it?" She just rattled off a whole bunch and I really liked her. I really like her. I'm looking for good stuff out of her. Oh, my god, a female surgeon in Duluth running a med school that's for family doctors!

DT: [chuckles]

JB: It's fine [whispered]. It will be fine. We've lived through psychiatry, endocrinology, pediatrics, microbiology, clinical psychology. We can probably handle a surgeon. People worry about this stuff. I don't worry about it.

DT: That's true. It is interesting that for a family medicine oriented medical school that there hadn't been a family med dean.

JB: Of the three candidates in this last search, two were family docs and one was Paula. I looked at the CVs [curriculum vitae]—I wasn't on the search committee—before they came for their presentations and said, "What the hell is this one all about?" She came and blew the others away. No two ways about it. One of the others was Byron Crouse who is a good friend of mine and who wanted to come back and be our dean some day. I think

he still would be really good at it. No question. But I think Paula just outdid him on this one. That's the way it goes. I begrudgingly had to say, "That's the one." I wanted to say, "That one," but I just couldn't do it. I wouldn't have been honest.

DT: When it comes down to leadership, there's a difference set of qualities than what it means to be a particular kind of physician.

JB: Oh, yes, yes. Right. I think Byron would have been a good leader, too. The third candidate, I thought was pretty weak. She was a department head in family medicine at a big school, so she can't be *all* that weak. I thought compared to those two, she was considerably weaker and she pulled out pretty quickly afterward, after the interview and said, "I can't match what they're doing there." So it came down to Byron and Paula. I think both would have been good. I just want to see how much Paula does. I think she's going to do really well. I think Byron would have, also. But I don't get everything I want in the world.

DT: Going back to the really innovative things about the early curriculum and I know these things continued with the preceptorship, and, also, the fact that you had community physicians as teachers. That was not something that was embraced in other medical schools.

JB: It was not only not embraced; it was discouraged.

DT: Right.

JB: People would put them down.

I remember meeting with the six med school deans in Pennsylvania once. It was a weird day. They wanted to know how they could increase the number of primary care physicians from their institutions. They're very, very urban. So we came in, so I'm sitting with these six deans. I said, "Why don't we talk a little bit about what exposure your students have to primary care." They said, "Well, they don't." I said, "Why do you think they would want to go into that?" "We want some of them to go into that." I said, "Right. That's why we're talking. Have you considered placing them with primary care docs in your community that you have trained?" I didn't want to go too far. They said, "Well, no." I said, "Why not?" "They're primary care in our community. We know what we have to teach them." I said, "If you don't let them go a little bit, they're never going to see those models. If they don't see the models, they're not going to espouse primary care. They're not going to adopt those. If you think you can loosen that up a little bit… How would it go over it you went to the faculty in medicine and said, 'We've got these really good general internists in hospitals in town here. I think we should roll some of our students into rotations with them'" "Oh, ho, ho. We'd have a revolt. We need those students here to do all the work here." I said, "Well, you know, I had planned on a longer meeting, but I don't think this is going to go anywhere, because if you're not willing to trust your primary care docs and use them as models, the ones that you have trained, you're not going to get anywhere. How are you going to change your culture to

make that happen?" They said, "Well, we're not." I said, "Well, then, I think this conversation is over." They said, "Well, okay." It was like a twenty minute meeting. I'm saying, "Get real. It doesn't work." They were just so tunnel-visioned about if it doesn't happen…" It was kind of like [John S.] Najarian, "We train department heads for other medical schools. We don't train surgeons for Hibbing," that kind of approach. Really bald-faced. Right. Oh! Okay. So I tucked my tail between my legs and headed for the door.

Yes, it was innovative and we *did* run into problems with the accrediting groups coming in. They said, 'You cannot do that, blah, blah, blah, blah." I said, "Wait a minute. These are all board certified family physicians trained by other schools because we haven't trained anybody yet and who have excellent reputations in the community and who are taking good care of patients. Why can't we use them as models for our students, because that's our target?" "We don't do that. We train them all where we are." I said, "We don't have any clinical facilities. So where would you suggest we go for the first two years? We can't ship them to Minneapolis for a day a week, because that would be prohibitively expensive. Given the resources we have here in Duluth, what do you think we should do?" "I don't know, but it's not that." I said, "Show me where it's not working. Here's our board scores and here's how they do in matching." This was on the second and subsequent visits and all that stuff for accreditation. I said, "Show me where it's not working. I think the proof is in the pudding. We're eating this pudding, so why can't you take a taste?" "That's not the way we do it." I said, "No, it's not the way you do it at your place. I'm not telling you should do it this way in your place. But with our goals and our mission, this is the mission fit for us. They're also learning basic sciences. They're also doing well on their clinical rotations in all the other specialties. What's the problem?" "Well, we just don't think that's the way to do it." I said, "Well, as accreditors, you have to judge whether or not the program is effective and functioning well, and meeting the mission as we set it. So your personal opinion doesn't count." So we disagreed. I got in trouble with a number of accrediting groups, because I just don't fart around with that. Sorry. It's just dumb. Students are at stake here and our patients are at stake. They were getting good training. It was more modeling than learning. We didn't say, "You have to go learn cardiovascular medicine from a family doc in Cloquet." You learned that from a cardiovascular physician, but you learned what that means in a smaller community from that family doc in Cloquet, Minnesota, or Bigfork or Staples or wherever it is. We don't expect you to learn all that stuff there. That's why we have the University, but we also have a state and community to take care of and that's what we have to do. Those communities need care. That's another community that we have to pay attention to. So we've had some interesting discussions with people over the years.

A lot of it depends on who is on the accrediting team. Some of that's dumb luck. Some of that's manipulatable…mostly dumb luck. AMA [American Medical Association] and AAMC [Association of American Medical Colleges] pick who comes on those teams. The last site visit team for the Med School at the University of Minnesota included a family doc from the University of Washington, who is well aware of the successes of the Duluth program. That made it a lot easier, a lot easier. Another one of those site visitors was a person who's been fairly strongly involved at a national level on Native American

health. *That* made it a lot easier. We had nothing to do with that. We just got dumb lucky. I'll take luck over talent sometimes. Okay? So it worked very, very well.

You've seen the last accrediting report for the Medical School. The strengths were only found in Duluth. They were not found here. That had to stick; that had to stick in somebody's throat. If I was the dean down here, I would have been livid. I would have said, "This has been a managed visit. How did those guys screw us?" That's what I would have said.

DT: [laughter]

JB: It was not managed. We got lucky. I'll grant you that, but I don't think we managed it. Once they were onboard, it was fine. It's not like this Med School campus is bad. It's a really great Medical School. They didn't get any praise on that one. That was really unfortunate. As happy as I was that we got the good mentions, I also had this…ooooh, it's not all good if that's all they're seeing, because there was a lot of other good stuff they missed. Like I said, it was *somewhat* funny, but in kind of a pathetic way.

DT: Were there other medical schools in the 1970s, especially among the new medical schools, that were, also, doing things like Duluth, kind of incorporating similar models of work with community physicians and preceptorships?

JB: It started growing after we got going on it. There were a number of people that had incorporated family medicine into their mission, established family medicine departments, but there was no huge differential in terms of output. Yes, there were departments established. People who'd go to that school saw family medicine, it hasn't been effective, for whatever reason…for whatever reason. What set us apart right from the beginning are our numbers. They were fantastic. Nobody else could touch them. That doesn't mean other places are bad, but they're not as passionate, dedicated to that part of the mission. Now, there are other programs. Howard [K.] Rabinowitz at Temple [correctly Jefferson Medical College, now Sidney Kimmel Medical College, Philadelphia] has got the PSAP [Physician Shortage Area Program]. What he does is he takes a small fraction of their incoming class and manages that small fraction to go into rural and family medicine and do stuff like that. He has curricular additions and differences that he does with the students. He's quite successful looking at that fraction of the class. There are other schools like that that will kind of carve out and say, "Okay, this part of the mission is going get met by this group." Some of those are doing very well now.

The package in Duluth is what I think makes it a killer. We have biochemists saying, "Family medicine is the way we want you to go into practice." That doesn't happen elsewhere, so we've got total buy-in, which makes transitioning to new faculty a challenge for us right now. There's only a couple of us left. Arlen [R.] Seversen in anatomy is still very active teaching on the faculty. He got Teacher of the Year *again* this year. That dog. I keep telling him, "Arlen, would you, please, retire so a few of us *might* have a shot at it?" Geez! Irritating. Between [Arthur C.] Art Aufderheide, who is

since deceased [August 9, 2013], and [Patrick C.J.] Pat Ward, who is now retired, and Arlen, those three won Teacher of the Year for the basic sciences probably twenty-one of the last twenty-five years, which makes the rest of us just *angry*.

DT: [chuckles]

JB: But they are very, very good teachers.

Arlen and I are the only two left who taught the charter class. So those days are shortening. We don't know how long that's going to last. God willing, a long time. Now, we're starting to see the kids of our former students coming through med school and into practice and all of that. The first time I see a grandkid come through the door, I'm walking out the other one. That's ridiculous.

DT: [chuckles]

JB: I think the oldest grandchild—I track these things, because I want to know when I'm leaving—one little guy, is a thirteen- or fourteen-year old now. So, potentially, six, seven years from now, we could have a *grand*child and I will not be there…I will not be there. If I am it will be coming in for free coffee or something or the free parking place.

DT: Fitzhugh Mullan and colleagues, I think it was in 2010, published stats on…

JB: The social mission of medicine [The Social Mission of Medical Education: Ranking the Schools].

DT: Yes. It's not surprising that they have one medical school, two campuses now, the University of Minnesota. I would have really been interested if they had disaggregated UM-D from the Twin Cities campus to see what the stats were.

JB: Those data are freely available, have been reported many places. You can, generally, count on me or one of my colleagues presenting those data almost annually at either the Society of Teachers of Family Medicine or the National Rural Health Association. They are all U of M grads.

DT: Right.

JB: The people that publish these results want to retain their sanity. I don't blame them. When does a program deserve a special spotlight recognition? The American Academy of Family Physicians gives out awards to the schools that have a good track record for getting people into family medicine. The University of Minnesota gets one every time they give one. Okay? [Macaran A.] Mac Baird goes and accepts this wonderful award. If you look at the output from Mac's department, from the Minneapolis students who start down here, and you look at who's driving those figures, Mac should not be accepting that award alone. He should have Ruth Westra with him. He knows that and, once in a while, will even say, "Thank you," which is kind of nice. We are driving those

numbers that make Fitzhugh Mullan's social versus academic output measures and all that kind of stuff. I thought that was a refreshing article to read. I might not have done it exactly the same methodologically.

I think it does raise an interesting question: What is our obligation as a land grant University to the people of Minnesota? Yes, I know, the Legislature only provides about x percent, a single figure, to run the Medical School. I remember Frank Cerra saying very publicly and openly, "Maybe it's time we are no longer part of a land grant university. If they're not going to fund us, why should we pay attention?" which, I think, is politically a really stupid thing to say to legislators. But that's Frank. Whatever he wants. I would never say that, because they could pull the plug right now, the wieners. What is our role? I think our role has to be to pay attention to the health care needs of the people of Minnesota in more than just advancing research and knowledge. That's critical and this University does a *fantastic* job with that. But that's not all there is and I think that's what Mullan was saying. We need the Harvards. No question in my mind. We need the research efforts of the major research universities to solve the health problems of mankind.

Eventually, they might even look at some of the *real* health problems that we have, but they haven't yet. Some of the most common ubiquitous problems that we all have as humans never get touched by research. [sigh] I don't understand that, but that's okay. That's only part of our mission. I don't care if you're a private medical school or a public medical school, our mission has to include the care of the people, bettering the care of the people. We have system after system working against that. We have the huge healthcare systems which have to be more attendant to, basically, profit and loss statements than to care of patients. We have people running those systems who do not understand patient care and can't and I think, even worse, won't. There are ways to understand this without being a physician. Healthcare economists, for instance, have a really good way of looking at certain aspects of it.

In our Legislature right now is Jennifer Schultz, who is a healthcare economist. She's a first-termer this year. She's on the faculty at UM-D. She's very, very bright, very passionate about healthcare, but looks at it from a standpoint of healthcare economics, so a macro… I recommended when she was elected to a number of our college and clinical colleagues that they establish a preceptorship for her where she can job shadow some docs. We can pick the docs, docs that are beloved by their patients—obviously, I don't want to distort anything, just to show what happens behind those little closed doors. What kind of trust relationships are built? What kind of excellent communication is established, the real personal care that a physician can give? I don't mean to exclude other healthcare providers. But we're in a medical school and I'm going to talk medicine. Okay, fine. They didn't do that. I suggested to the County Medical Society that they do it and all that. They haven't done it. I will continue to do that, because I think it would make Jen even a better advocate for health, the more she knows about it. But she's also got a day job on the faculty. She also has her kids to raise. The poor lady is just working his buns off. She's just very, very bright and very good. I pray we don't

burn her out after a session or two. That's the only person who knows anything about healthcare in our Legislature.

[Thomas] Tom Huntley just retired. He was on the faculty at the Med School in Duluth for years and years and years, a biochemist. He was the go-to guru for healthcare. He's a biochemist. He's a good biochemist and he's a good guy and he knows a lot.

There's not a physician in the Legislature. Our lobbyists for physicians and medicine in the Legislature are ineffective when you contrast what they've been able to maintain or get strictly from a lobbying standpoint, as you compare them to the nursing profession and other healthcare providers who are chipping away *all the time*. Physicians are going a little buggy with all this kind of stuff. Well, then, get your act together, folks. Take back your profession. Take it back from the bean counters. Don't let people tell you that you only get twelve minutes per patient. If you believe you need fifteen, take fifteen. If you cannot be the patient's advocate for that, maybe you shouldn't be in medicine. Maybe you should just go and be one of those bean counters and make a lot more money. What do the CEOs [chief executive officers] of those places make and they never see a patient? I don't think that's very healthy.

The Mayo Clinic is still largely physician run. It still has a relatively good reputation. I think people kind of think the Mayo is okay. If you go talk to the docs at the Mayo, yes, they complain about things, but not in the same way. There's a certain trust in their administration because they know it's physician dominated. There are physician executives. They've gotten there and grown through practice or some have gone directly, but they're physicians. It's that clubby thing again. You tend to trust people like you and you tend not to trust people not like you whether that be Duluth versus Minneapolis or physicians versus non physicians or this or that or something else. There's always a little bit of that kind of stuff. But the Mayo is a really good model. It's not perfect. I recommend to all of our students that they take a rotation at the Mayo just to see what it's like. They will be sending patients there. They should know what they're sending their patients into. Mayo does a fantastic job of follow up with physicians on all of the work, much, much better than this University does.

Enough of that. I'm sorry.

DT: No, this is great.

JB: And I have no opinions.

[laughter]

DT: What led Bob Carter to step down as dean? Was it in 1974 that he stepped down?

JB: Yes. The exact thing? I don't know. I think he was a start up dean. He knew coming in that if he was going to get this thing off the ground fast, he was going to have to step on some toes and be really aggressive and ignore certain things, which would get

some people PO'd [pissed off], but, too bad. He was given a real strict deadline. "You will be open September of 1972 and you're coming in late 1970, basically. Oh, by the way, hire a faculty, figure out a curriculum, select students. We don't have a building, so we'll have to do something there, and go!" Holy crap. He pulled it off. It's amazing…it's amazing. He and Lyle French would have some differences of opinion. When it comes to that, if it's a v.p. versus a dean, I will bet on the v.p. every time and I'll come out a winner. I won't be 100 percent correct, but will be more correct than incorrect. Exactly what did it? I don't think I'll ever know what the exact precipitant was but I remember when Bob came back from a meeting with Lyle in Minneapolis and walked into my office and closed the door behind him, I said, "Oh, shit."

[chuckles]

JB: He said, "I think we're going to have to have a leadership change here." I said, "Okay. Uhhhhh…" [unclear]. I said, "Well, that's going to get dicey, isn't it?" He said, "Yes, it is. We've got to figure out what to do, because it's not going to be long before the announcement is made that I am going to be stepping down." I said, "Okay." I'd been through a couple of those down in Ohio. And I knew this was coming. I came in as an associate dean and Bob and I had a pretty good relationship right away. I think he felt that he could share a lot with me that he did not feel comfortable sharing with a lot of the other folks who were just starting to get their feet on the ground. He was a pediatrician and acted like it at times, like protective of children. Some of the faculty, I think, maybe resented a little bit of that, but most of them loved him. They didn't have to worry about a thing. Uncle Bob would take care of everything, the favorite uncle kind of thing. When he stepped down, I said, "You know, Bob, this is going to devastate the faculty. I'm not in favor of it, but I understand. It's going to devastate the faculty." He said, "I know. We've got to have somebody come here that is just going to make sure it works."

I said, 'Who are you thinking of?" He said, "I think Aufderheide," who was down at Saint Mary's [Hospital, Duluth]. He was the pathologist and had been kind of the path [pathology] guy that everybody talked to. He had put together some of the pathology teaching, but still was fully employed at Saint Mary's and Saint Luke's [Duluth], at different times. Art could work both sides of the street really, really well. Everybody loved him. So I said, "That's a great choice. You better talk to him fast. I think you're telling me it's happening pretty quickly." He said, "Yes, it will." I said, "You better talk to Art then."

So he talked to Art and Art said, "No. I can't do that. I don't know anything about it." Bob said, "It's for the future of the school. You're a native. You've got to step up." He really put the squeeze on him. Art very begrudgingly said, "Okay, but only till June 30. Then, I'm walking, because I have to head for the tundra." He was going on a North Pole expedition that had been in the works for a long time, following the earlier [Ralph] Plaisted expeditions at the Pole, the first blah, blah, blah. [Plaisted's first polar expedition in 1967 failed when the ice began to break up. Plaisted and his team succeeded in reaching the North Pole in 1968.] Bob, at that time, said to him, "I'm sure we'll have a new dean by then.

DT: [chuckles]

JB: My personal belief is that Bob knew very well we wouldn't have a dean by then. This was like seven months off. You can't mount a search for a med school dean and have somebody onboard, leaving wherever they were, but Art bought it. So Bob called a faculty meeting two days later and said, "For the good of the order, I'm going to be stepping down as dean." There was a [gasp.], literally, the sharp intake of breath, like, oh, my god, it's all over. Uncle Bob is leaving. Oh, my god, what are we…? He said, "But I'm not leaving the school." [sigh] "But I don't know what I'm going to do." [gasp]

DT: [laughter]

JB: "We're in good shape." [sigh] "But we're not sure of that. [gasp] Oh, my god. He was playing this really well. He said, "So we've got an interim that we're proposing to Vice President French. I have an informal okay from him that this happen. Art Aufderheide is coming in on an interim basis." Everybody…"Oh, that's horrible, but, boy, it sure could have been worse. Art is known and trusted. Okay."

Exactly what it was that broke the camel's back, I don't know. I know Lyle had made some comments about the youth of the faculty, that it needed more senior people, and all that stuff. The accrediting group had come in and said the same thing. So Bob had gone out and quickly hired two senior faculty, Lloyd Beck to head Pharmacology and Tom Hamilton to head Microbiology, both professors elsewhere. Tom was at the end of his career but good for probably a good five [years] and would come with Betty Hamilton. His wife was kind of his right and left hand person and was a great caretaker for him in terms of getting things done academically, as well as everything else. Tom was the old senior hand and Betty was the one that kept everything going. Lloyd Beck came in Pharmacology. Lloyd was a taskmaster and said, "We're going to shape this place up. The students will jump to Pharmacology. Everything else can take second place. We're going to make…" My god. Germanic. To the faculty who were there, he said, "You people who are here now are too young. You don't know what you're doing." Oh, it was terrible, just terrible. He didn't last all that long. He finally lost the position after a student filed a grievance against him. It went to formal hearings, lawyers, the whole shooting match. That was when John LaBree was dean. That was a terrible time. I'd be at home—I live right near campus—and there would be a knock at the door. There would be some students representing the people that wanted Lloyd Beck tarred, feathered, and sent out of town on a rail. I would spend about an hour talking and saying, "We have to calm down. We have to take things rationally. You have to learn pharmacology. This is an important topic. You're going to be using drugs the rest of your…" I put water on the fire as much as I could. The next night, there would be a small fraction of the class knocking on my front door and we'd talk about how we could save Doctor Beck. "We think Doctor Beck is the greatest thing since sliced bread, blah, blah, blah." So within the class, there was all this stuff and every damn night, one or the other group would be at my house. I was going crazy. I finally went to Lloyd and said,

"Lloyd, I want an appointment with your department because all I'm doing is your crap." [Doctor Boulger pounds the table] He said, "You don't have to do it. I'll handle it." I said, "That's what's getting us in trouble, man." I said, 'You've got to loosen up a little bit." If somebody missed three questions on a final exam, he wanted to flunk them out of med school. Oh, my god, man! Cool it. So it finally got to the point where formal grievances were filed. There were hidden tapes all over the school and all this other crap, lawyers, hearings, all this, a report to the dean, resulting in Dean John LaBree asking Lloyd for his resignation as department head and, then, trying to figure out who among these young faculty who were there would be willing to take on the department leadership with Lloyd in it.

DT: Mmmm. Oh, my goodness.

JB: *Oy vey*. [laughter] In a small shop, you have very few degrees of freedom. You've got four people in the department. One of them was the department head and was telling the other three to blow it out their ear. He's going to still be in the department. Oh, goodness! There were a lot of interesting things like that that happened.

Tom Hamilton, on the other hand was a storyteller. He would come in and tell the students stories about during World War One, the gas attacks and what kind of microbes were involved with countering this and that and all this other stuff. He did some consulting for the CDC [Center for Disease Control and Prevention]. Eventually, somebody would tell him something about microbiology. They gave him the Uncle Remus Award for storytelling. He was a good storyteller. Then, Betty would come in the last ten minutes and say, "Okay, now. Here's what you have to learn about microbiology." [Doctor Boulger taps the table several times]. "Here's where you get it. Go do that. Here's where the test is." It would be okay. Tom was okay. Fine, we'll listen to Tom to get to Betty. It all worked out.

DT: [chuckles]

JB: There's lots of stories like that.

DT: That's great.

JB: Students have been terribly, terribly patient, as most students are. They know that if you're working hard for them, it's not going to be perfect, but it's going to be the best you can do. If they don't think somebody is working very hard, they will not tolerate that. We've got a hardworking faculty, so we've got a pretty good life now.

So we brought in those two senior people. That kept the accreditors happy. I think it helped Carter a little bit with Lyle. It got him over one hurdle.

Then, I think Bob kept going down and saying, "We need more money…we need more money. We need more money." You get tired of hearing that. Always asking the vice president, so oftentimes coming in like that. I'm eventually going to say, "Yes, it takes

money. What are you doing to go get some?" So there had been some community fund drives and things like that. Before Bob showed up, the community had been very well organized, had gotten pledges from the Med School, blah, blah, blah, blah. When Bob came in, somehow that fell between the cracks and pledges were not followed up. After he resigned, I took a stronger role in the general administration, I was going through a lot of files looking for things—he kept his own stuff pretty much—with his permission, after he left. I said, "Can I go in there and find out stuff?" He said, "Sure, I don't care." Nineteen seventy-one dollars…$500,000. That's a lot of money. I don't know what that would translate to today. But you're talking significant bucks. They had collected about $50,000 and done nothing about the rest. Once Bob came onboard, it just somehow fell between the cracks. I said, "Wow. We can re-contact these people." Hell, they'd already given the money away, because nobody ever came back to them. But I found some other things like a couple of wills that we were in, things like that. I said, "Here's some money to be] cashed in." So we got some of that back. It was the early startup years. Bob was running back and forth to the Cities a lot. I-35 [Interstate 35] was not totally completed yet, so it took longer. There were hard times. So exactly what, I don't know. Like anything, it was high stress, a real need to get things done *now*. The University or Minnesota is not necessarily the best place for that, because it is deliberative at times and can appear to be slow and cumbersome. I think Bob just didn't have time for that. So he would short circuit the system. He would go around Lyle and I think that probably did him in. He went around Lyle with the Legislature a few times. That's the easiest way to get your butt in a sling. You just don't do that. If you're going to go see the Legislature, let Lyle know. He will say, "I don't want you to do that, but I can't stop you." At least he's informed then. I think that's true for anybody. If I'm going to go over and talk to the legislators, I'm going to let our campus dean know and I expect that she will let somebody else know or I will. I don't want to be in the business of sabotaging anyone else. That just kills you. I think Bob did some of that, looking for money more than anything, strengthening the program as quickly as possible]. I can't think of anything exactly other than probably a couple things like that that I know he did.

DT: Aufderheide was in the interim position for seven months and, then…

JB: Just for a few months, about three months.

DT: Then, John LaBree came in as dean for five years.

JB: About five years. Then, he headed back down here. Lyle hired him, basically, to do a really important job. He and [Theodore R.] Ted Thompson, who passed away about a year ago [Doctor Thompson died on July 28, 2013], were involved with trying to improve the University's standing and relationship with referring physicians. Those two did a great job of rebuilding the University's reputation, both really likeable guys, both very knowledgeable guys, and very trustable guys. If they said, "We'll go back and make sure that happens," and it happens, then everybody is happy. They both did a great job. They'll never get very much credit for that kind of stuff. It was really important.

DT: Then, you were interim.

JB: I was interim for about a year, maybe a year and a quarter, something like that. Interim is terrible. Half the people are telling you, "Don't do anything. Wait for the next one." The other ones are saying, "We have to move ahead, because we don't know who the next one is going to be." So no matter what you do, you're going to be wrong. *But* what do you do? You're probably going to be partly right, too, so it all works out.

DT: [chuckles]

JB: You can lose some friends in the bargain, because you have to make some decisions for the institution that they may not think is correct.

Sometimes, they are very personal ones, like every year at raise time. I hate that time, because dollars are symbolic. We're never talking very much money for raises at the University. We're talking a percent or two, which doesn't translate into huge, big money for anybody, but it's the symbolism of it. So if a department head here gets 2.15 percent and that one gets 2.13 percent, you think that person's evil and bad and this person is a god. No. I just was off by .002. Forgive me. Boy, that stuff is tough to deal with. The money isn't the important thing. It's all symbolic. So, when you are saying to people, "These are merit based," it means I will judge you. I *hate* that, but, still, somebody has to do it. The only alternative is across the board and that's not fair. The rich get richer; the poor get poorer. People get passed up. Gender inequities get perpetuated or other kinds of inequities get perpetuated whenever you use the formula approach. That's gotten this University in trouble, too. So that's always a tough time of the year for everybody and you can't keep everybody happy.

DT: Were you ever interested in being permanent dean?

JB: No. No. I think I tried to make that very clear to everybody. No. I just didn't want to do that. Not my idea of a good time. I enjoy working with students a lot. I enjoy working with faculty a lot. I enjoy working with most administrators a lot, but that's not all I want to do. When you get up to this level, that's all you're doing and you lose sight of why you're there, sometimes. I think that's really sad. I didn't want to take the chance.

The first position I was offered before I took the one in Ohio… I was offered a number of teaching positions and all that. The most lucrative one was one down in Iowa at American College Testing to develop what became the new MCAT [Medical College Admission Test] at that time. It was a straight research position, psychometrics and all of that, which I was capable of doing. I would have had a staff and publications coming out of my ears. When I went down there and they offered me the position, I said, "Okay, the other thing I want to know is… Here we are in Iowa City. There's a University here. I want to do some teaching." They said, "No." I said, "No? Among other things, that's good continuing education. It keeps you up with things and that, but, also, I think I would like to work with students." "No. This job is strictly research." I said, "Oh! well, I don't want it then." When I got home I said, "We're not going to Iowa, Dee." She said,

"Oh. What happened?" I said, "They didn't want me to teach." She said, "Oh, that's that then." That one was about the same time as the one in Toledo came along. Luckily, the Toledo one was fine. It was weird but fine. Med schools are weird.

DT: [laughter]

Going back to the mission of the UM-D Medical School… Once you had the focus on Native Americans, I'm wondering what strategies you had. I saw that you were associate dean of admissions in the late 1970s.

JB: Right.

DT: What strategies were there in terms of trying to recruit students committed to family medicine and rural practice and, then, also recruiting Native American students?

JB: Very different, those two. It was an evidence based approach in terms of selecting people for family medicine. There was a small amount of literature, not much, and we started doing studies very early about what are the determinants, the precursors, the correlates for the selection of a rural practice? Then, after that, what do those same things look like for outcomes in family medicine? There's a large overlap for rural family docs. For urban family docs, it was quite a bit different. So we structured our admissions accordingly.

The most common literature, which is not rocket science at all, is that it's very difficult to take somebody from Edina and put them in Bigfork and have them be happy, because there's no dale [shopping center] there, South[dale], Rose[dale], or any other kind. You're really recruiting, to a smaller community or larger community, a family. If I had my druthers, which I didn't and can't legally, I would marry them all off first before med school and I would make sure their spouse was very happy with small towns and had jobs there, if they wanted. Then, I'd have a tremendously higher proportion of wins. As it is, growing up in a small community is one of those predictors that is not perfect at all, but is the strongest correlate with happily practicing in a small community.

The second would be something that happens after admissions and that's having a curriculum that fosters it and reinforces it and a faculty that does the same. That combo doesn't occur in most places. That's where Carter's suggestion that we're going to hire faculty who are mission driven really made some sense. So you have an admissions committee made up of microbiologists and psychologists and all these people and instead of asking questions like I wonder how they'll do in my course, we're asking questions like how sure are we that they'll go to Ely—what are the precursors for that?—not whether they're going to be a successful medical student. What do you have to do to be successful in medical school? You have to be smart. You have to know some science stuff and you have to be able to relate to people. Okay. Make sure you've got that stuff. You can get that with MCAT and GPAs [grade point averages] and all that kind of stuff. The interview should tell you whether or not they have two heads and they can't talk to people and stuff like that. After that, you have to go with something else, because

anybody can fake anything for an interview. I can come in and I can convince anybody that I'm going to be a rural family doctor. But how do I demonstrate that? What have I done to demonstrate it? What is in my background that makes that believable? What is it that might actually fuel that for somebody knowing that you're not going to be perfectly predicting anyway? You're interpolating seven to ten years of intensive educational experiences that change people. If we ever turned out 100 percent of the class in family medicine, I'd resign that day. That's brainwashing. That's not education. If nobody ever changes, they haven't learned anything. The other thing you have to be able to do, then, is to settle for a *good* result, not a perfect result. You never get perfect, but you can get really, really good at it if you work it right. I think that's what we've shown up there. We did an evidence based approach.

Now, with Native Americans, it's different. The Minnesota Native American community has not developed, even to this day, a good, solid pool of applicants for the Medical School. The administrative change that we made then was to look at Native American applicants nationally. Even though we would love to have them all stay in Minnesota and practice, if we really take tribally oriented students, we will not get them to stay here. They will go back home and meet those kinds of tribal needs. If we lose some of those from Minnesota, I'm sorry. We're going to keep some of them, too. Again, we're going to have to settle for being very, very good but not perfect. That policy change we put in relatively early. We will look at that as national. We will not change our standards for admissions in terms of academics. I think if I had a look at the figures, I would probably say ninety-five percent of the Native American students who start in Duluth have finished, not really different from non Native students. So I think we're very careful and we're very supportive. We have the Center of Native American and Minority Health which has certain pathway programs that are, again, reinforcing, trying to get them to follow that. It's very difficult to take those two and marry them to] medicine and that. Family medicine is very strong in the Midwest, but it's not elsewhere. So you might get a Native student from Oregon and they'll say, "I like family medicine. I want to be a good rural family doctor," or "I want to be a good Native American doctor for my tribe." Well, okay. We can do that. We're not going to be perfect. You will actually detract, perhaps, from the numbers going into family medicine. We're not going to die. We'll be okay. Family medicine, we try to bolster throughout the curriculum by showing good examples of it.

It's very different today than it was then. Forty years ago in Duluth, most of the family docs were delivering babies. Now, in Duluth, all family doctors are in either the Essentia system or the Saint Luke's system. Some of the Saint Luke's docs are still delivering babies, certainly not all, and only one of the clinics, Essentia in Duluth, is still actively involved in family medicine, delivery, and OB. The rest are not doing it. So what model do we train to? The urban model or the rural model? Our students go out and they spend a weekend in Parker's Prairie and they see the doc doing everything. They come back and they say, "That's what I want I mean. That's what I think family medicine is." It's OB. It's geriatrics. It's peds. It's diabetic care. It's social work. It's all sorts of stuff rolled into one. It's taking care of the whole patient, not fractionalizing the patient. So that's the model they see more out there in the rural. The urban? That's changed to the

point where they're getting some good clinical experience, but they're also seeing the limitations of urban family medicine. How many family docs in Minneapolis deliver babies? I don't think there's too many of them birds left, you know. If you go to a smaller community whose hospital is still doing OB, you'll find the family docs doing it. To me, it's a crying shame that—okay, it's after July 1—in the Arrowhead Region of our state, that big Arrowhead Region, no OB is going to occur in that region other than in Duluth. So, if you're in Grand Marais, you're going to deliver in Duluth. Now, I'm sorry, in a January 17th snow storm, Highway 61 coming down… I don't want to do that. Thank you. If you're in Bigfork, Minnesota, you'll have to deliver in Grand Rapids. That's forty-three miles on this kind of a road. In the summer, it's a beautiful drive if you're not in a rush, like maybe in labor. What the hell? Why are the women of our state tolerating this? When is OB going to wake up and say, "We have to deliver babies where the babies are, not where we are." How can we do that? Can we use telemedicine for that matter? Can we co-locate some other way electronically? How can we support our family physicians out there? How can we get the hospital administrators to quit running in fear from the malpractice claims and deliver care for their patients? This is unconscionably bad medicine. Well, they chose to live there. They knew they'd have to give up OB care? I don't think they knew that. What the hay? Isn't that horrible?

DT: Yes.

JB: Tell people in Rochester they all have to deliver in Minneapolis. See how that goes. It doesn't work. There's still a lot of stuff that has to happen. We still are turning out a lot of family physicians who are capable of doing OB. Some choose not to. That's their business. I'm not about to criticize or praise that. They have to do what they think is best for themselves and for their patients, preferably for their patients than themselves. But, I'll tolerate it. But to shut out physicians from practicing at the top of their skill set… If we do that to the nurse practitioners, they get all bent out of shape. If we do that to the PAs [physician assistant], they get all bent out of shape. If we do that to anybody, they get all bent out of shape. But family docs? They don't count. That attitude is still there. I thought it would be much better by now, frankly. These are competent people. Why should I have to go to a GI [gastrointestinal] surgeon for my endoscopy and/or whatever? Okay? Every ten years, I have to see one of those birds, so they can do a very simple technical procedure of looking inside me. Hopefully, the next time that comes up in my lifetime, there will be some non-invasive way to do it.

DT: [chuckles]

JB: I'm not saying a trained monkey can do that, but a well-trained family doc can certainly do that. When I call Essentia and say, "It's time," they say, "Which surgeon do you want to do it?" That's a waste of the surgeon's talent. It's a waste of everybody's talent. Why are we doing this to ourselves as a society? It's just terrible. Why is it that a family doc in the middle of South Dakota or North Dakota can do procedures like that and feel bad about raising their price to $400 when it costs me $4,000 in Duluth to have a surgeon do it? Why don't I drive over to South and North Dakota to have that done or, in

my case, to Moose Lake, Minnesota, forty miles south where the family docs are doing it? Are the results equivalent? Yes. It's not rocket science. Is it a critical blow to a practice not to be able to do that? Procedures pay. That keeps you open. So when you do spend a half hour with that sixty-three-year old woman who is now diabetic and needs a lot of care and personal attention to help her reform her life habits, you've got it for her. But if you're not open, you're not going to be there for her either. So there's real effects, ramifications for care that the bean counters don't pay attention to. That's really sad.

Enough. Sorry. I keep going off on these things.

DT: No, it's great and it resonates so much with the article I wrote on the development of family medicine.

JB: Family medicine is not developing anymore.

DT: Yes.

JB: They should have changed their name to referral physician. Then, the other specialists would have paid more attention. They wouldn't be in business if it weren't for the family docs.

DT: They wouldn't have been threatened [unclear].

JB: If you take the top position earners in our society across the board and reduce their salary by only three percent and take that three percent and spread it across our primary care givers, the gap changes remarkably. They won't give up the three percent to get that kind of effect for their colleagues. That's not very nice. They should be ashamed of themselves.

DT: If the reinvestment model wasn't so procedure heavy either.

JB: We see it with Obama Care [Affordable Health Care]. I hate the term Obama Care but everybody knows it. We see it in an increased emphasis on preventive medicine. We have seen an increased emphasis on keeping people out of the hospital, yet we persist on training our students *in* the hospital, which is really dumb because that's not where they're going to practice. They're going to practice over here. But we need students to run the hospital because otherwise we're going to actually have to hire people. Oh, no [whispered].

DT: [chuckles]

JB: [unclear] to all the residents. I don't know what's going to happen to residency training. That's going to blow up. Hundreds of students that finished med school last May didn't get into residencies.

DT: Wow [whispered].

JB: And we worry about workforce shortages, but we're not going to train them because there aren't enough residency spots? Well, there are enough residency spots. They don't want to go into family medicine. They don't want to go into primary care. They all want to become ologists.

DT: Yes.

JB: Ologists are favored and loved and paid. Now, if you change the pay, some of that will change—not all of it. I don't know any rural family doc who is out there because of or in spite of pay. They're out there because that's where they want to be. So if you select based on money, it's not going to work. If you select based on what you want to do, then it works. It's not rocket science, I don't think. It really shouldn't even be called innovative or anything anymore. It's a known kind of thing, but nobody pays much attention.

Anyway, I'm sorry.

DT: I'm curious about the relationship between the Duluth Medical School and, then, the hospitals, Miller-Dwan, Saint Mary's, and Saint Luke's. There seemed to be in the late 1970s the establishment of the residency program in family medicine.

JB: Right.

DT: Was that a combined residency between those three hospitals?

JB: Yes. The AMA basically said, "No more rotating internships as of x year." You're the historian. Nineteen seventy-three, was it? Maybe 1974. Anyway, no more rotating internships. So everybody has to do a residency. Okay, so now we've got to have a family medicine residency. There had been two very successful internships: one at Saint Luke's and one at Saint Mary's in Duluth, for decades. Excellent training. Lots of people did those and went straight into practice. Lots of people did those and went on to other specialty training, really good programs, one year a little bit stronger at Saint Mary's and one year, a little stronger at Saint Luke's, but both pretty good. So the graduate medical education picture in Duluth was pretty strong. Well, now, you've got to have a residency. That's a three-year dollar commitment in addition to training commitment and everything else. I'll credit Bob Carter a lot on this along with the three hospital administrators at the time who saw this coming, decided there's not going to be internships anymore. We've got to create a residency if we're going to have graduate training in Duluth at all.

It became a four-legged stool supporting that financially: the Medical School-Duluth, Saint Mary's, Saint Luke's, and Miller-Dwan. It wasn't that long before Miller-Dwan, they didn't leave the consortium, but they didn't pay into it as much anymore because they didn't think they were getting the value partially because of the specialty nature of Miller-Dwan Hospital, burns, psychiatry, a couple of other things like that, but not the

kind where you have your normal first-, second-, third-year residency in family medicine rotating through. So you didn't get much assistance out of it. So they're saying, "Why are we paying in?" I can understand that. They didn't want to abandon it either. They thought it was really good to have everybody in the game. So they kind of started chopping down their payments meaning Luke's, Mary's, and the Med School had to go up a little bit if they were going to stay stable. As inflation keeps occurring, those have to keep going up. Well, the University draw came out of our budget and, eventually, got to the point where we went and lobbied at the Legislature, got a special appropriation to support the residency via the Duluth Med School budget. They added money to the budget at that point. Mary's and Luke's just kept ratcheting it up.

Now, they were not getting hurt financially, because they were getting direct [direct medical education – DME] and indirect medical education [IME] costs from the feds out of Medicare. My suspicion that I cannot prove is that they were making money on this. If they would have not had the residency, they would have had to hire people with no IME and DME cost attachment. So they would have lost that money and they would have had to pay these people. It would have been a real blow to them. I think that's probably still true today, that the federal direct and indirect medical education cost to residencies…most of those dollars go to Saint Mary's and Saint Luke's still. They, then, turn them over to the residency. Do they turn them all over? That's a monitor's problem. I'm not going to get into that. I know darned well, over the years, they haven't.

The good nuns who were in charge up there… The nice thing about nuns is they can't really lie. They think that's morally wrong to do that. They don't have to tell everything, but they can't look you in the eye and lie. I remember having a conversation with Sister Kathleen Hofer. I said, "Sister Kathleen, come on. You're making money on this, aren't you?" She said, "There are many, many costs associated with this that don't necessarily show on the books." I said, "Sister! Look me in the eye and tell me you're not making money on this." She said, "No. I can't answer the question quite that way." God, I loved her. She was really nice. Oh! They were making out like bandits. They would get these direct and indirect medical education costs, feed part of that into the residency to support the residency, and keep the rest. So it was kind of a good deal for them.

Those reimbursements have decreased as costs have increased, so I think there's a line that was crossed, eventually, where it actually might cost them a little bit if you don't look at the replacement cost for what the residents would be. If you look at that, then they'd be much more happy to support the residency, because they'd get a lot more bang for the buck that way than they would if the actually had to hire people to replace them.

I was in on that residency really from before, talking about bylaws and all that other stuff, how are we going set it up. Duluth Graduate Medical Education [Council], Incorporated.\, DGMEC, a horrible acronym… What the hell does that mean? What it did was it got every party to the table and every party saying, "We need this for our community. We need it for our hospitals. We need it for our labor. We need it for education. We want to continue the graduate tradition in Duluth. We're going to squabble, but let's squabble here. Now, if you put in an MRI [Magnetic Resonance

Imaging], I'm coming after you. That's different. But for this, let's agree we're going to work together." And it worked beautifully for a long, long time until about three or four years ago.

Miller-Dwan had been gone a long time, because Saint Mary's/Essentia bought Miller-Dwan. So, now, they've got two pieces of the pie. Since they don't exist, they're not paying in anymore, so they lose some of the income. Essentia didn't ratchet theirs up to match that, so Saint Luke's had to come up with some more answers. The Med School…they kept saying to us, "You've got to come up with more, too." We're limited by the state appropriation. If we got a cost of living increase on the appropriation, we'd give that to them, but if we got our budget cut, we'd have to cut ours and they wouldn't get as much. So we were becoming a smaller financial partner but still had a lot of intellectual capital and we had the affiliation with the School of Medicine in Duluth.

Now, when we merged into one big happy, dysfunctional medical school, then the affiliation agreement had to be changed to be with the University of Minnesota. In optimal circumstances, in my opinion, that would have been with the Department of Family Medicine on the Duluth campus. But some years back, when we got merged, the Department of Family Medicine on the Duluth campus no longer was a department. It became a section of Mac Baird's department. I still don't understand that one. Mac said it was for accrediting purposes. That's a bunch of bull, too. I know Mac really well and I like Mac but I think he's blowing smoke on that one. Okay? He liked acquiring things. He acquired the Saint Cloud residency. He acquired the Mankato residency. He acquired all the residencies he could. There are a couple in the Twin Cities here that are holding out, like HealthPartners and United. He's not going to get his clutches on them. But he built more residency stuff into his department, including Duluth, then. So the actual affiliation agreement now is with the department down here, which means if there's a program director change, Mac has to fire him or something and Mac has to hire and Mac doesn't know and can't know what happens in Duluth very much. That kind of was a stupid administrative arrangement in my book. Maybe when Mac retires, the next one in will say, "You guys keep your problems up there." The financial picture changed. Then, the affiliation picture changed. Then, Mac started asking questions like, "Why don't you guys come up with more money for your residency up there, because I don't have any money.

DT: [chuckles]

JB: "Then, why do we have an affiliation with you? It's not getting us anything." When we were affiliated with UM-D, we could at least argue with them. Arrrhhh. All this stuff.

So right now, the payer proportions have changed. Saint Luke's pays in less. Essentia/Saint Mary's pays in more. The Med School is pooping around someplace in here. Mac doesn't kick in anything but the affiliation agreement there. Because of this change, it's now becoming pretty much an Essentia branded residency but Saint Luke's still wants to be a participant. But the paycheck name on every faculty at the residency

says, "Essentia" at the top, not "U of M." That's a game changer. They have just last year dropped from ten residencies per year to eight. It's not like we don't need family docs. So it's all of this; it's all money. I don't know how it's going to resolve. I don't see any more money coming in. I have offered repeatedly to write HRSA grants for the residency and told, "No, we don't want to get into the funding cycle." They'd rather take the cut than go out after money? But that's their business. I was on the board from the very beginning until two years ago, at which point I was summarily replaced without even a thank you note. Oh! Those wieners. They just don't want to be around right now and that's okay. I can live with that. But I feel bad for them and I kind of still want them to be successful. I just can't do anything with them; that's all.

But they still want me to be on the Admissions Committee. Oh, okay. I guess I'll take that as sort of a compliment. I don't know. The faculty there are fine. They're good people. It's this administrative stuff that kind of gets in the way sometimes.

It's still a three-way residency: Essentia, Saint Luke's, *the* University. The University has changed. Essentia has changed. Saint Luke's is pretty stable and, Miller is no longer there. Okay?

DT: Yes.

I'm curious about the fact that now there are only eight spots in the three-way residency in the Duluth part. That would seem to affect the pipeline, the people graduating from Duluth who might want to do their residencies in Duluth.

JB: Well, a little; not much. We've never been a captive residency. I think the most that I can remember is one year, which I didn't particularly like but it happened—what the heck—where five of the ten spots were to people that started at UM-D. It's never been more than half and it's usually less than that. I think that's really healthy for the resident's education. It doesn't do patients or anybody else any good if you turn to your colleague resident and say, "How do you do that?" "I don't know. I was in class with you. None of us knows how to do that." That wouldn't be so good. So I like a lot of mix. There are a lot of good residencies around in family medicine. So if some people don't get into the residency in Duluth, they're going to get into another good residency. That's okay. What I think I see is a slight fall off in quality of the resident applicant to the Duluth program. I don't think we're getting necessarily the best that we can, because there has been a lot of turmoil over the last three, four years. That word gets out among students and applicants really quickly. "They've got problems in Duluth. Shy away from that one." Well, then, you get this swirly thing going. This is a tough one. That's tough to do. They're working hard at it.

Another problem in medical education in general, and I think it's true here, too, is where do you find residency faculty? It's a hard job. You get a lot of calls. You're backing up the residents all the time and all that stuff. The pay isn't that hot. There aren't very many rewards other than seeing your protégés do well and that's great for a while. Eventually, you say, "All my colleagues are making now twice as much as I do and I'm

working twice as hard as they are." There's not enough justice there. So I think that's taking its toll a little bit, too. It's really tough to recruit faculty for your residencies in family medicine, as well as everything else. If you're a big center, it's a little easier.

DT: Yes.

JB: If you're in Mankato or if you're in Duluth, Saint Cloud… The faculties we have going right now are really good. I don't know how we're going to be able to sustain it. I'm worried about that a little bit.

DT: I'm glad you brought up the relationship to the Department of Family Medicine here in the Twin Cities. I was wondering how that relationship is between the Department of Family Medicine here and, then, the Duluth campus and how it's changed over time.

JB: Legally, I suppose, we're a section of this Department, blah, blah, blah. Ruth Westra and Mac Baird get along fine. Most of us get along fine within the two departments. But there's not a lot of this closeness stuff and I don't think there will be. One hundred and fifty miles is a long way. We have annual joint meetings. Those are relatively well attended. When everybody comes together, everybody gets along pretty well and all that kind of stuff. Then, you go home and it's like everything else: you start running your tail off on the things that you didn't get done because you were at the meeting. It's just a time/pressure thing. There's no enmity or animosity at all, nothing like that, I don't think. I don't think it makes sense. Don't get me wrong. Budgetarily, the budget comes out of UM-D to pay the people in Family Medicine at UM-D. So Mac doesn't have anything to do with that. So follow the money. I don't know why we have that. Like I say, I think it's just an anomaly that probably will change someday.

DT: You touched on this already a bit, but I wonder if you have more to say about the relationship between UM-D Med School and the rest of the UM-D campus.

JB: Not strong. Again, I don't think there's animosity, but I think it's largely individual. It's still strongest, I think, in biochemistry, because physically, the chemistry building is right next to ours and the biochemists and chemists get along fine. There's a little bit of teaching across the boundaries but UM-D is totally enrollment driven for budget. If a UM-D student takes a Med School course, we get the tuition. They don't. So there has been, over the years, a distrust, a fear and, to my mind, student disservice being made. We keep the courses separate and even though we might teach a really crackerjack course on pathophysiology, it won't count for a major in biology or in phys or something at the undergraduate level because they're supposed to take the courses there. It's a money-driven thing. Whenever that happens, then, there's some personalities that get involved, too. I don't think the personalities are that involved with things. It's just strictly money. Everybody is working hard as it is. Oh, let's find more work to do for the same amount of pay. You don't get anything for it, other than the wonderful satisfaction of seeing your students do well. That sounds like a Steve Martin routine about Christmas time. Anyway, there hasn't been an increased emphasis on doing more teaching at the entry level, because of, again, the emphasis now within the Academic Health Center, and Med

School in particular. Doctor Jackson is very, very forceful in his pushing for research, research, research, research, research. Well, now we're talking teaching, teaching, teaching for no money, no money, no money, no benefit, no benefit, no benefit. Oh, let's see, which will win?

DT: Hmmm!

JB: Right! There's no encouragement for that, at all. There is still some teaching going on. It's not like we hate anybody. That's not where the bennies are going to come from. When you start making pronouncements like, "You have to have your research and we have to have so many publications per year…it has to be first and last author only," all these other metrics, and all that kind of stuff Nobody talks at all about, "We have to really make sure the undergrads at UM-D are well educated in the sciences." This one is going to trump this one any time. Until it's valued, it won't happen and it's not valued right now.

DT: Yes.

JB: I don't see that happening in the future. When it does, then we're going to run into the financial thing again. If they take your course, then we want the money in our budget. That's always going to be there.

DT: I'm glad you bring that up. One of the questions I was going to ask you was how the faculty in the Med School had, since the Med School began, kind of balanced those expectations of teaching, research, and service.

JB: Poorly. I think there's a fundamental attitudinal difference on the Duluth campus. I think faculty who come up from the Twin Cities to teach see we are much, much more all about the students, much, much less about research careers. It's not that we don't like research. Everybody likes research. It's fun. It's valuable. It's good. It gets very good funding. Students are still going to have to get that good education. So we've had our reward system structured more toward students than toward research. Not that we don't like it. We were down to like twenty-two, twenty-three faculty. Run the first two years of Med School down here on twenty-two or twenty-three faculty and that includes our clinicians. That's ridiculous. The workloads are way out of whack.

Maybe I haven't sent this to you. Maybe I should. I did a thing for the Blue Ribbon Committee on workloads at Duluth on the student contact hours among our Family Medicine faculty, for instance. Remember, they're not doing rounding in hospitals. This is active teaching hours…350 to 400 hours of contact time, not prep time. Well, when are you going to do anything else? That's crazy. Every one of our clinicians is working off campus one day a week, so they're only there for four. That workload is huge for the small number of people, I don't get how this is working at all, frankly. What's the average teaching load for medical students for the departments down here in the first two years? I don't know and I'm not going to start digging around to find out, but I would be hard pressed to believe that it's more than we're doing. You can only spend an hour

once. If you're spending it teaching or preparing for teaching, you're not working on your research over here. Now, I'm not saying we work forty-hour weeks and then we go home, because that's not true. But there is still so many hours of productivity in a week. If you're spending more of it here, you've got to be spending less somewhere else.

Then, you take something like service. Okay. You've got an admissions committee. How many faculty can you have to select from at the U of M Medical School-Twin Cities to sit on an admissions committee? Now, how many do we have here in Duluth? We're going to exempt department heads and the deans. Now, we're down to sixteen, seventeen people and we've got 1400 applicants for sixty spots and we've got to have some of the people pre-screening to get that number down to a reasonable number to interview. And how's your research going? Did you get that grant out? Holy crap.

I gave my notice this year that I'm not going to work on Admissions. To hell with it. I've been working on it for forty. I'm through. That's it. I'm doing it again, because one of our faculty passed away and when you lose one out of the few we have, it really has ripples all over. So I'm back in it, again. I'm pre-screening hundreds of files. It's not like I look at GPA.s, MCAT's and throw them. No. That's not how we do it, because every one of those is potentially a really good candidate and they've worked their butts off to get it together. To not respect that in them is not nice. So it takes a long time. I spend on average maybe—I know if an applicant heard this, they'd be disgusted—ten minutes per application. They probably think I should spend at least an hour.

DT: [chuckles]

JB: Well, they probably would, because it's their life. I could understand it if they thought that. I still can't do it. When you take that times hundreds…oh, and, then, your teaching. Oh, that's right, where am I in terms of lining up preceptors for sixty first-year students locally and a hundred and twenty students in rural every year, free? I think you know. Our goal for the rural is to have the physicians actually house the students when they go out for five weeks. Okay. So I go home and I talk to my wife. "How would you like to have a student?" "Oooh. "

DT: [laughter]

JB: It's a sell…it's a sell. The students all want to have only the very best teachers all the time.

So that's what I'm riding on, plus my teaching in social and behavioral and in population science and death and dying and this and that and all those other things. Oh, that's right. I've got those grants to write. Uhhhh! You go a little nuts. I thought I would slow down by this time in my life. As it turns out, it may have but I've slowed down even more.

DT: [laughter]

JB: So it's been a zero sum thing. I still love going into work every day and I still love going home at night, so I don't have a bad life—just a weird one.

DT: You mentioned Dean Brooks Jacskon, that he's really pushing the research.

JB: Yes.

DT: I'm wondering did things change, also, with the merger of the two schools?

JB: To some degree, yes. There is one Promotion and Tenure [P & T] Committee now for both campuses. Prior to that, we had our own P & T Committee and we'd make our recommendations directly to the vice president, not to the dean of the Medical School as we were separately accredited and everything else. So that is, I think, a substantial change. We are held to the same promotional standards but without, we feel, the same kind of support for what we're doing. So to the degree that they emphasize research more and we have to do more teaching—I mean *have to* because we don't have the horsepower—we're disadvantaged. It's not quite fair. I'm not saying that our candidates have been treated unfairly by the P & T Committee, because I don't think they have been. I think the persons that have gone up have been promoted, would have been promoted here, there, or anyplace else. I do worry about some of our newer, younger faculty. It's tough to get a research career going today, they think. They think it used to be that I'd just have to call Washington and they'd send me money. It was so easy back then for you old guys. I'm sorry; it never was quite that easy. I do understand pressures they're under.

The new faculty today are different, much like the students today are different than they were thirty, forty years ago. They want different things out of life. They look at it as their first job, many of them, instead of a job. This is where I'm going to be. The same thing for practitioners. This is my *first* job out of residency, not necessarily my job. Okay, fine. They're much less permanent. They have much more emphasis on needs for family than was present in the past, not that that wasn't there but we just didn't talk about it as much. I think the large increase in the number of women in the medical student body as well as now on the faculty… I think we probably have more women faculty than men in Duluth. I don't really count, because they're all faculty. They're colleagues. I don't like doing head counts on stuff. But men and women are different. I celebrate the difference. I don't complain about it; I celebrate it. I think we have to be respectful of that. How that plays out when you have an influx in the system seven-year tenure code, no exceptions—there are some schools that bad; the University, I think, is a bit better at that, a bit, not greatly better—that doesn't necessarily jibe too well with the way life is lived today. I don't know how I would change it myself, but I think it's certainly worthy of discussion. I don't think it lowers the standards. Never mind. I won't go there.

DT: [laughter]

So you were interim dean again for a third time, 1987 to 1988. I'm curious if, in those three stints as interim dean, you observed any major differences in your experiences.

JB: I drank more each time—no.

[laughter]

JB: The first one was a short stint. It wasn't very long before we knew that John LaBree was coming, so I was able to work with John in transitioning. He was new to medical education at the med school level, so there was a lot of things that he had to figure out. I was helping him with that more.

The next time, after John and before Paul Royce, some budget things came up that were very difficult, retrenchments and that kind of stuff. We had to make some tough decisions there about where the money was going to go. My goal—I was running the budget—was to have every faculty member and one staff clerical-type professional-level member covered fully by the budget. So if every grant went away, nobody lost their job. That was my goal and I made it. That's not the way we are anymore, because more people are on soft money because that's the way things are run. Getting to that point, we did have some budget cuts. We were able to get through that successfully without losing anybody. So I thought that was very good. It was also very difficult, because we had to have some tough decision making about how funds were going to get allocated. That's the kind of thing that everybody's worried about. Whose ox is going to get gored? Everybody's is going to get gored a little bit. So we had to make some cuts there. Departmental budgets got cut a little bit. You try to equalize it as much as you can, but it's never equal. I think we came out of it okay. Paul Royce inherited, maybe, a little bit of carry over from that. In his first year, there was an even greater retrenchment. So he got off on a tough economic foot. After following a bad year, he got an even worse year. I think that colored the faculty's opinion of him a little bit, that he was getting to do some more cutting. Nobody lost their job, but we also didn't increase where we wanted to. That's the same as losing positions really, except everybody you know was still there. You just don't have some people that you didn't know yet.

The third time between Royce and Franks… Ron had tried to marshal support for going to four years in Duluth. He had some legislators on his side. He had done some behind-the-scenes work. He knew what the cost would potentially be. We were probably in as good a position as we could have been without any support from the Twin Cities. It got to the point of hearings and everything else. Then, President [Nils] Hasselmo went over to the Legislature and said, "About this medical school thing in Duluth, the University doesn't want it, so let's not talk about it anymore." When the president says that, nobody talks about it anymore, because it's easy for everybody then. The legislators don't want to talk about it because it isn't going to happen. It's a waste of time. The president just totally put the kibosh on it. It was just one swell swoop! Bambo! It's gone. It wasn't too much longer after that that Ron moved on. I don't know that he felt pressured to move on from administration for trying that. I don't think that was necessarily the case. I think he was ready to move on, at that point. He moved on to East Tennessee State [University] in the medical school out there where he was both dean and vice president, so he got promoted. It wasn't like he was a bad guy or evil or anything like that. So he

left then. I think the contributing factor was that he attempted the end run to try and get it to four years. People down here didn't want that. That's all there was to it. "No need for that…no need for that. You're transferring all your students down here." There was some logic there, too. How would you possibly do that? I think that's still worthy of discussion.

As I talk to Brooks or others, Aaron Friedman before that, there's a big concern about the quality of clinical training—that includes students in the Twin Cities—about the numbers and can we handle the community hospitals and some of the relationships out there…not being very positive to the point where last year, they talked about cutting the required OB rotation from six to four weeks. Well, I think there's a lot of babies being born down here. So I think maybe the problem isn't that. I think maybe the problem there is our relationship with our community. Nobody talks about that. Nobody wants to talk about that, because then you'd actually probably have to do something about that. Brooks was very clear, "We're not going to increase the number of students. We don't have the clinical capacity to do it." I say, "I agree that you don't in the Twin Cities. If we take this kind of a look at medical education and it has to be in the Twin Cities only, you're right. But if we look at the state as our medical school…" I know that if a student does a six-week rotation in surgery in Bemidji or does a psychiatry rotation in Willmar or does a dermatology rotation in Winona, they are going to get a high quality education, particularly if the University pays attention to that and makes sure that happens and it's done with the blessings of the University and if the faculty here are behind it, we don't have to feel restricted to education by location.

With the increases that, hopefully, someday we'll see in this University in terms of telecommunications… Telecommunications to the Duluth campus from the Med School down here have absolutely abysmal. We have the connection to the Medical School address and we might get sound but no picture. Come on. It's 2015, for god's sake. I can do better with tin cans, almost. Nothing happens down here. It's never on our end. It just drives me batty [whispered]. They don't have their act together. It's really irritating. It costs everybody then. You get all set and, then, you're going to have to cancel again. Geez, Louise! It's 2015.

DT: That's crazy.

JB: It is for the relatively small amount it would take to improve the infrastructure and staff it. That's where they get cheap: they won't staff it. Then, it doesn't work. It does take some attention. Look what we're doing with telemedicine in terms of service delivery for patients. Why can't we use that as an educational thing, as well? This place is not ready for that. I think we could do two years out of Duluth if we used our statewide clinic sites but not destroying our current use in the bargain. Keep our first two years exactly as it is. It would take some work, but I bet we could pull it off. I think the students would get a great education. We might have to, again, take on the accrediting group and convince them, but if we use our heads, do it right, collect the data, show them the evidence that our students are getting at least as good an education, no matter whether you look at national award scores or some other measure. The game is over. If we don't

do that, we deserve to get our butts kicked. There's a way to do it and there's a way not to. I think we could pull it off. I can't do that. I'm at the end. I'm not at the beginning. I might have tried that thirty-five years ago. I'm not sure I'm up for that right now. There's talk of a medical school in…what's the little town [Gaylord, Minnesota]? Some city councilman [Administrator Kevin McCann]…they've got a vacant high school, so he says, "Let's put in a medical school."

DT: Oh, my goodness."

JB: Ashland, Wisconsin, was talking about putting in a medical school. There's now a new medical school campus in Green Bay [Wisconsin], opened this fall already, opened this month. There's another one opening up in central Wisconsin next fall. Wisconsin sees a shortage of physicians, the same shortage that we have, but they're doing something about it and we're not. We're going to have a D.O. school come in here. Somebody is going to come in here and they're going to make the University look sick. Then, the legislators are going to divert funding from us to them when we should be able to pull it off. That irritates me. I think we could do it. It would require a massive amount of effort and preferably some younger blood.

[laughter]

JB: I think it could be done. Conceptually, I think it's sound. It would require a lot of work. But to say, "We can't possibly because we're limited in our clinical resources in Minneapolis" is dumb. That's just dumb. Saint Paul tried to take us on and lost because our communities demanded that we deliver. Okay? It didn't work. Sorry. We're still there.

DT: [laughter]

JB: I think we have to do better for the people in Minnesota. The odds of using that also is a way to balance the physician distribution. If they're out there, they have to have teachers. You're growing some faculty out there. If they have the U of M name on their paycheck, you're buying some loyalty, too. There's plus, plus, plus, plus, plus. The minus is hard work. I've never been involved with an organization like the University that's afraid of hard work. We can do this kind of stuff. The question is *will* we? I'd like to see some signs of that *will* pretty soon.

DT: That's sounds like a great…

JB: It can happen. If we don't do it, somebody is going to roll in. Nothing against the D.O.s, but I don't like their model as well. I don't like their model as well at all. It's not as well controlled. I think education has to have a modicum of control. I want high quality and I want somebody to be able to look at us and say, "*You're* doing a good job. We see that." I don't want them to say, "Well, we think you're doing a good job, but you've got your people scattered all over the country and we don't know what the hell they're doing." That's the D.O. model and I don't like that.

DT: It's interesting that for…

JB: Gaylord, Minnesota. I'm sorry. Google Gaylord, Minnesota, Medical School. [laughter] It's strange, but true. Saint Thomas made a run like that with Allina.

DT: Yes.

JB: If Saint Thomas and Allina can't pull it off, I don't think Gaylord can. That's just a guess.

DT: It's interesting that Minnesota only has two medical schools for a state of this population. I know that there is still, obviously, a large rural population, but given how many medical schools are in Illinois and Wisconsin has more than…

JB: They're opening up new ones.

DT: …apparently more than two now.

JB: Yes.

DT: Yes, it is surprising.

JB: I think what's interesting in Wisconsin is that both of these new campuses are coming out of Milwaukee's Medical College of Wisconsin, not Madison. The private school is serving the state's needs. The state school…whoops. What? It doesn't make sense.

DT: Maybe it has something to do with the fact that the state school doesn't get any [unclear] from the state.

JB: Neither does the private.

DT: Yes.

JB: Maybe it's not about money. Maybe it's about will.

DT: I'm really glad you brought up telemedicine. I was going to ask about the Center for Rural Mental Health Studies that you direct. First of all, when was it established?

JB: [pause] It says on the website. About ten or eleven years ago.

DT: Two thousand and three is when the website talks about projects being started.

JB: It conceptually started a couple years before that. It takes time to get these things established and all that. It started with Gary Davis and I. Gary was the department head

of Behavioral Science at the time. He was precepting for Clinical Psychology down at the residency and talking to one of the docs from Bigfork, Minnesota. He said, "What do you guys need up in Bigfork that you don't have?" He said, "We need mental health. Everybody needs mental health care." Gary said, "Well, maybe we should come up and talk about that." So Gary and I drove up to Bigfork one day and talked with the docs, talked to the hospital administration, talked to the nursing staff, talked to the priest in the community and the minister in the community, talked to the bartender, did a community assessment and, sure enough, mental health was a pressing need. Then, we came back and said, "What do you think it will take to solve this?" They said, "We need a psychiatrist." We said, "Sorry, you're done. You're not going to get one. You've got one in Grand Rapids, forty miles south of here, that doesn't even pay attention to you and is only half time and is getting ready to retire. That's the closest you've got. What do you need in terms of functional service for your patients?" They said, "The thing we need most is backup. We really aren't comfortable with what we're doing, sometimes."

Then, we cooked up this telemental health scheme, found some money, put a unit up there and at the Med School, and set up, basically, a consultation unit, and started in Bigfork. It's grown since then. It's all been soft money. There was, maybe, $20,000 of state money, startup, that the dean allocated just for initial equipment and stuff like that. After that, all the equipment has been bought for the center from grants, all the staffing, and everything else. It was sort of donated space. We use space in our building but really it's all faculty and all donated. I don't think the taxpayers are getting too upset.

The model is Doc Jones says, "I've been working with Mary for five years. I've had her on these meds. It's been holding so far. Now, I see something going awry. I'm not sure what's going on. I need a new set of eyes and ears." So they go to their family doc's office. They don't go to a mental health center. We're trying to eliminate stigma. They go to the family doc's office. We hook into them, do usually a one-hour—it can go longer—consult interview. When we're done, we hang up. Preferably the doc comes in at that time on TV, too, but that usually doesn't happen because of scheduling out there. We call the doc and say, "Here's what we saw. Here's what we would recommend. Have you thought about this? Have you thought about the blah, blah, blah? We'll send you a written notice. What we do is, basically, copy that same notice to the patient so it's totally transparent." "Well that… Well…" We said, "We have to do it that way. We don't want miscommunication. We don't want them thinking we're telling you one thing when you're telling another. Baloney." There was a little bit of resistance at first. Since then, no problem. They really like that because everybody is on the same page. Possible follow up maybe, but not the intention to ever keep that person as a patient. We have some of those. We have some do-gooders on the faculty.

[chuckles]

JB: "They can't get in anyplace else." That's not our problem. "But they need help… I'm going to see them anyway." I lose every time, every time.

DT: [laughter]

JB: I don't want to be a hard nose about it, but there's cancellations. There's non payments. There's all this kind of stuff. Mental health care is reimbursed very, very poorly. At first the insurers wouldn't pay anything. That's been changed now, but we're still financially unstable. We have a couple of faculty who see patients that way and that's about it. At the same time, we've had 1200, 1300 patient contacts. So it's not like they're sitting around doing nothing. We have a little contract with our Human Development Center. We have a couple psychiatry people that come out like one afternoon a month, something like that. They charge exorbitant rates. It's grant money, so we get away with that. But grants are running out.

My discussions in the last two weeks, three weeks have been can we sustain? Can we stay open? The need is there; there's no question of that. The patient satisfaction is there. There's no question of provider satisfaction. There's no problem there. The problem is it does take some money. We have to maintain an electronic medical record. We have to maintain the equipment. We have to do this. Where do we go for help? We've written grant after grant after grant and were successful, but… [sigh] I'm getting tired. It's, basically, running on the faculty. One particular person, Doctor Claudia [V.] Weber, is a saint. You talk about gangbusters. This is a fully licensed Ph.D. clinical psychologist who is also a pharmacist, so knows psychotropics better than anybody I've ever met in my entire life. That's the one who is in charge of doing all this stuff now, making sure things work right and all that. We're not maltreating her; I don't mean it that way. But she's had to do a lot of stuff that she's not trained to do just to keep it open. She's just a good heart. That's the people I get to work with every day. God, I'm lucky. She and I have had some very difficult decisions. Paula Termuhlen, the new dean, we've got a meeting with her coming up in a couple of weeks. I'd like to keep it going. I think it's a great service for our colleagues out there. I think it fits our mission beautifully: supporting rural health. The only question is money. I am trying to cook up schemes all the time. I'm not quite at bake sale time, but getting there.

DT: [chuckles]

JB: I'm not a clinician. I didn't want this. I didn't want to be director. I wanted Gary Davis to be director. He's a clinician. He said, "No, no. You're better at this administrative crap." He doesn't want to have anything to do with it now that he's no longer the dean or anything else. He's ready for retirement [whispered]. He says, "Let it go." I said, "It's your baby. Remember, you're supposed to protect your baby here. Remember that?" He said, "I can't. I can't do that." I understand that. I don't have to like it, but I understand it.

DT: Are you doing evaluative studies in the center, like measuring outcomes and things like that?

JB: Minimally. Some, but not much. Again, it's a matter of, okay, we've got staff like this and a load like this.

DT: Yes.

JB: Oh, yes, let's put in some more pieces of work for her to do. We do do the patient satisfaction, patient outcome, provider satisfaction, all that. It's not research research that's fundable.

DT: That's what I was wondering.

JB: That's the kicker. We've thrown out some HRSA grants and come close, but no banana. "Well, if you were only bigger." Well, we can't get bigger until we get the finances. It's one of those things.

DT: I know that Stuart [M.] Speedie and [Stanley M.] Stan Finkelstein in Health Informatics down here…

JB: They had huge HRSA grants for years.

DT: Right.

JB: They could not get anywhere with mental health. We tried working with them, tried other things. They could not get anybody here to sit on the other end of the TV.

DT: Hmmm.

JB: Psychiatry is over booked. These people are working their buns off. In an academic setting, you're also trying to do research, the whole thing. Stu was never successful in getting the mental health going. Some of the other stuff is easy. If you get a good derm [dermatology] problem, you can do a lot. Oh, yes, that's fine. You can schedule right around the doc in an office and all this other stuff. It's not a medical emergency. You can get your PharmDs to do a lot of that good stuff. We're talking about diagnostics and assessment and things like that take time and that's not reimbursable anywhere near what the cost is. So Stu dropped that part. Physics couldn't sustain it. We haven't had any recent conversations about it because things haven't changed.

Yes, the University has this great telemedicine thing but not necessarily the telemental thing. I could make money on telemedicine easily. There's a lot of really good models around. I don't know what the Med School here is doing on telemedicine. Stanford is doing a lot. They're doing really good stuff. Mayo is doing a lot. UM-D is starting to do some good stuff. I'm not sure what we're doing.

DT: I think the telehealth project that Stuart and Stan started officially ended. The evaluative part of the project ended, but I don't know if clinically it's still ongoing. I don't think they've published on it since the mid 2000s.

JB: Not for a while, yes.

DT: The Institute of Health Informatics has gpTRAC [Great Plains Telehealth Resource and Assistance Center] now which is where their telemedicine, telehealth services are located.

JB: Right. That's Mary… I'm blocking on her name. I hate it when I forget a name. Mary DeVany, I think. We're not affiliated with them. I've written to her a couple times. We talk, attend meetings together, things like that. She said, "Maybe we could do some stuff together," but they're working overtime, too. It's again [unclear] if we had more staffing. "You can't have more staffing, because you don't have any money." "Can you give us some money?" "No, you don't have enough staff to get the money." It drives you crazy.

DT: Telemedicine, it's a great…

JB: It's where we *have* to go. If you want to retain your rural health workforce, you have to support your rural health workers. One of the things from the past that has been working against that is this tremendous sense of professional isolation. It's really hard being lonely out there. We have counties where there's no docs and we have counties where there's a doc and a half and they don't have much support.

It's really assuring to a doc… Example: Cook, Minnesota. I get a call one afternoon from Doctor Harold Johnson up there. "Jim, I've got a patient in the hospital. There's some suicidal mentation. I want to discharge her. I don't want her to go home and kill herself. I want to know what the risks are." "Can she come over to where we do the TV consults? "No. I don't want to get her out of her room right now." So, okay. "Do you have a cart? Throw all the equipment on a cart and wheel it to her room. We'll hook up down here." I grabbed one of the people who was around who was really good and I said, "Here's the deal. This is going to be uncomfortable for you as well as for everybody else. They need an evaluation. Can this person go home and not kill themselves? What do you think?" "Oh, god, I hate these. These are terrible. You're never sure." I said, "Right. That's exactly where the doc is. Now, if you're both not sure together in the same way, that will be good. If there's a difference of opinion, you're going to win and you've got the risk. Go." "Okay." It got done. The doc got on and said, "What do you think?" "If the patient will make a contract with you to come back and see you tomorrow or a couple days later or a couple days after that so you can check and see how she's doing, if you think she will do that with you, it's my bet that this will work out okay if she goes home." And it did. The doc out there, "Oh, my god, what do I do?" It all just came together right. It was dumb luck. This guy happened to be around at the right time and they did have a cart and…and…and. Sometimes, nice things happen. How many other times has that poor guy worried to death all night long wondering if Mrs. Smith would even show up the next day or if he'd read the obit [obituary]. What a tremendous service to those folks to give that kind of support.

That's why it should stay. That's why some of the costs should be paid by people.

DT: Should be reimbursed.

JB: It should be just to be fair. I'm not looking for a tilted field. I want a level field. It's taking a long time to get there. Mental health [support] in general is terrible. You don't have people wanting to go into psychiatry anymore because of the whole med management. There's no interpersonal stuff. It's like pushing pills all the time. I wouldn't want to do that either.

DT: That really is cut down to like fifteen minutes.

JB: Yes. It's just a constant stream. I wouldn't want to go to med school and residency training and all that to do that!

DT: Right.

JB: That's where you get a PharmD and say, "You, sir…you ma'am, *you* are going to be *the* one that I'm going to talk to about this. If you need something, you can give me a buzz. I'll back you up." I happen to believe that there's more to dealing with patients than just symptom management. We've got to get at the root cause. We're only treating the symptoms with the pills. If you don't change something before that, they'll always be on the pills. The pills won't always work. So I don't know. I feel bad for psychiatry as a field. Then, you look at who's going into it and you worry more. Is there a more culture-bound area of medicine that psychiatry? Sixty-percent of the people going into residencies in psychiatry are non-U.S. citizens. I have nothing against them. You've got to fill the residency spots. Boy. Put me down in Iraq and say, "Now, relate." I can't. I can't do that. Maybe over years, I could acquire some sense of confidence. But, boy, drop me in now? I don't think so. That just won't work. I would have a hard time in the Twin Cities now living in Duluth.

DT: [laughter]

JB: I'd like to say the future is bright. I can't say that right now. I hope we can keep it open. We've talked about everything from cutting physicians to half time to… I've got a department head discussion coming up. Can we use Doctor Weber more in teaching and maybe offset some of the cost of teaching? Well, but that's not how you build a research department. I don't know what I'm going to run into there.

DT: I hope you figure out a way to keep it open.

JB: Oh, I do, too.

DT: The Rural Medical Scholars Program seems to be a fairly recent initiative.

JB: It grew out of the Family Medicine preceptorship rural program that we started in 1973. That's when the students go out, stay with the docs, and all that. But the initial iterations, the first real implementation was in the second year of medical school, three

times for three days. So we'd ask the docs to put the student up for two nights three different times. We were able to pull that one off. Okay.

Then, when the curriculum got revised some six, seven years ago, our Rural Medical Scholars Program was proposed. I talked with [Raymond G.] Ray Christensen who is the chief proponent of extending it even more. We had, by that point, extended it to four three-day sessions, one at the end of the first year to kind of be a capstone for the first year. Then, the curriculum committee came in and said, "Well, you should have more time." I said, "I'm not sure we can pull this off. Remember, these are all volunteers." Four days, three, two…uhhh. I had done a survey of the preceptors, so it could be data based. I said, "If we should do this, what would happen?" They said, "If you should do that, please, don't call me. I have a hard enough time. Now, we're up to four two-nighters. It's getting a little dicey at home and all that stuff." So I said, "I highly recommend we not do this." The curriculum group said, "We're going to make it work." I said, "Well, we'll give it a try, but I've got to have some flexibility then." I like what it has become. I do like more time out there. I do like the shift in focus toward community and doing community assessments, doing that while we're out there rather than just shadowing a doc. I think that's much better for the student. The experiences they get out there within the community are really enriching for the student. The guts of it is still working with the family doctor. That's still strong, still valid. Students come back and they say, "Now, I remember what I went to med school for. This is what I want to do." It's very reinforcing. I think that really helps keep our numbers up. It is difficult to recruit. Now, we're with three one-week sessions in the first year and two two-week sessions in the second year. So we're bridging the years. We have some preceptors that say, "Well, I'll take one every other year." Okay. Then, I have to find somebody else for the other year for every one of those. There are some that say, "Maybe every third year, I can do it." Some say, "Every year." We've got one person, in particular, that I'm thinking of who, basically, built a small cabin on his property for the student to stay in.

DT: Wow.

JB: I said, "Actually, I want them in a bedroom next to you so they understand…" No.

DT: [chuckles]

JB: We broadened it a little bit. We now ask students—an email went out this morning to the incoming class—"Do you have housing anyplace in the state where you might want to do these rural experiences?" We would prefer it not be their hometown; although, there are some students who say, "I would really love to work with my mom. She's a family doctor and I think she's a damn good one. I think I could really learn a lot from her." Do I say, "No" to that? It depends. I always check with mom before I say, "Yes" to the student because mom might not want him to do that with her—or vice versa. Sometimes, the dad will say, "You've got my son as a student. I want him assigned to me." When I talk to the student, "Uhhh, I would love to see other models as well," very diplomatic. No way. At which point, I have to say to dad or mom, "Our rules kind of

push us away," or "Yes, it will be fine." That's on me. They know that and I know that and it all works out.

We're always trying to line up good sites. We're always losing people. People retire. How do you replace them? We had a guy at Ortonville for twenty-two years who took a student. He took a faculty position at UND [University of North Dakota] a year ago. He's now trying to capture my spots in Minnesota, that wiener.

DT: Oh! [laughter]

JB: I went over and had dinner with him and some of the docs in Park Rapids that he was trying to recruit into his program. [laughter] I know I'm going to lose some of my western Wisconsin spots to the people at Green Bay and in central Wisconsin, too. They're going to be coming in and they should. They should be serving their people. I think that's right. I'm not going to like it.

A lot of this is now very personal stuff. We had one student two years ago who said, "I just don't know what I'm going to do. I really want to do this. I'm not sure I'm physically able to do this." I said, "What's the problem?" He said, "I'm a celiac." I said, "Hey! so am I." "Oh, okay. But I still don't know how I'm going to do this." I said, "I can tell you what I'm going to do. I'm going to put you in Grand Rapids with Doctor So and So. His wife is a celiac. That's all the kind of cooking you're going to get. You're going to be gluten free." "Oh, my god!" It worked beautifully. I only know that because I know them, because I'm out there, because I'm rubbing elbows and talking about things all the time.

That takes me out of the Med School. That's a good/bad thing. Boulger is just out screwing around with the family docs, again. Not everybody appreciates that.

I was sitting at home on a Sunday night two years ago and I get a call from the wife of the preceptor. She says, "This is Carolyn L." I said, "Oh, hi, Carolyn. How are you?" She said, "Well, I've been better." I said, "What's the problem?" "I've got Mike with me. We're down at Saint Mary's in Duluth." They lived in Grand Rapids. I said, "Ohhh, really?" "Yes, he just had a heart attack. He's worried because we're supposed to have a student showing up tomorrow morning." I said, "I don't think he's going to get discharged by then, is he?" She said, "No, but he's really worried about it." I said, "Tell him not to worry about it. I'll get back to him in a half an hour and it will be fine." So I called one of his colleagues over in Grand Rapids and said, "You don't know this but Mike is at Saint Mary's in the cardiac unit. We've got a student heading out to your shop tomorrow. Do you want to take him?" "Sure, no problem."

Nobody else I work with, unfortunately, can do that. Emily [C.] Onello, whom I'm working with now, been working with the last two three years, I'm taking on the road with me to all these places giving her a history of every shop as we're going in and introducing her to all these people, so that when I'm gone, and I will eventually be gone, she's there and groomed ready to go. We're co-directing it now, which is the way I think

the University should do things, orderly transitions rather than chaos when we can. We can't always predict everything, obviously. To the extent we can actually plan, we should plan. That's the kind of stuff that makes us work. Without that kind of on-the-ground stuff out there… I can walk into virtually any clinic in Minnesota and I've been there before. That's a lot of miles…that's a lot of miles. I'm getting tired. They're always welcoming. They're always kind. For many of them, they say, "This is the first time anyone from the University of Minnesota has ever been here." Even the some of the larger sites tell me that. I know that's not true. I know they're out there, some of them. There's always an agricultural agent from the University that they should be familiar with. So there's some University presence there. I've run into those birds once in a while, too.

That program is now five days and maybe a touch more. At the end of the first year, they're out there for a full week and, then, possibly, Monday and Tuesday of the week following. They have a choice. They can stay out there for two more days or come to Duluth and attend the annual Rural Health Conference for the State of Minnesota. The people that run the Rural Health Conference are good friends of ours. So, basically, for twenty bucks a head, they let the students in. Meals are included and all that stuff. They know where their bread is buttered, too. This is their future workforce. This year, for various reasons, that two days wasn't available, so we filled in with some other things. That's when we closed out the year as a capstone for the first years with a fully rural thing.

Then, we bring them back for debriefing and ask them to bring back the stories and share with other classmates and do exercises like, now, you're talking to your colleague here. "You were just in Park Rapids. You're recruiting that person. What do you have to show medically? How are you going to recruit that person to your shop? What's good about it? What are you still working on? What did you find out about the community?" So they give a community assessment to one of their peers. That's really good stuff; it's really fun. Then, you hear things like, "I'd never really experienced anybody dying with me before." You can't teach that in the classroom, not very well, at all; although, I show a film every year on a video tape of one of our former students who passed away while he was a student from cancer. It's very gut wrenching. I say, "He sat right where you're sitting." All of a sudden, the whole room changes. Wow. Then, we start talking about death and dying, planning, working with patients through their whole life, not just the fun parts of life. Even the fun parts at the end…they get to the hospice. They get to this and they get to that. So they walk out with stuff that no one in med school has and that's what matters. It's just really fun, but it's also time consuming and taxing and all of that. Like I said, we don't have many people to do it. That's the sad part. We keep trying to recruit new faculty. We need more money.

Enough. I'm sorry. I didn't mean to go off on that.

That's a program that we want to stay. It is getting more difficult. One of the big problems is every health science school wants their students out rural, so these people are *besieged* with requests from N.P.s, [nurse practitioner] P.A.s [physician assistant], APNs

[advanced practical nurse], this, that. D.O. schools from other states…Dartmouth will buy a spot. Some of these places, like the D.O. schools, some offshore schools, the privates, pay places to take the student and we don't, which is another reason why we're out there with our hand out all the time. I want them to know that we're thankful. We can't pull it off without them. It's getting more and more competitive out there. We're going to, probably, have to start pushing brand loyalty, saying, "You are our physicians. You did get trained at the U. We need you. Those other people are really important, too, but…"

DT: They're not training people for the state.

JB: Even if they are… A nurse practitioner, a P.A., they're great to train. But if those are going to be our faculty, we've got to figure out a way to pay them. This University is not going to do that, I don't think. Okay? I brought this up at that Blue Ribbon Committee. It was not well received by the University.

[laughter]

JB: But, too bad. I was there representing rural Minnesota. The hell with that.

DT: Yes, it's really too bad.

JB: Yes, well, there's not enough money.

DT: I've asked all my questions. Do you have anything else that you want to share about UM-D's history?

JB: [pause] I am really proud of what's happened there. When I say faculty, I don't mean assistant professors of… I mean everybody in the place, literally, are faculty. I don't care what their title is. If a student needs something, they can go to any office. Our doors are *always* open. I have seen faculty stop in the middle of an experiment to help a student with a problem. It is so student oriented that it's almost scary. It's the way I think education should be.

[break in the interview]

JB: I think the other things that we do in education are critically important but have to be secondary to education. It is a medical school and the school part is just as important as the medical part. I think we kind of live that there. I think that's really good. I don't know how to put that into historical context. Caring, I think. Seventy-five years ago, before big money took over medical education, there was much, much, much, much more of that. I talked to some people who went through med school here fifty, sixty years ago. Their memories are great. They remember working with the great physicians. Granted, memories are always selective, too. Okay? I *don't* hear that from the recent grads. I don't hear that. Medical students here are *terribly* disadvantaged. One of the points I tried to make with the Blue Ribbon Committee is that this campus needs a medical school

building for students, for their education, not spread out over to here, not having administration on the sixth floor of Mayo [Building, Twin Cities campus], not having people running all over hell down Washington Avenue trying to find somebody in family medicine, but a place the student can identify and really start grooving on medical education *here*. There's not that deal here and it could be, I think. It would be a good thing. I don't know if that will make it either. I think Frank Cerra killed off the last one like that and put another biomedical district in, one of those other ones over there that make money, I guess. Education costs money. It doesn't make money. People, I think, have to remember that. If you really want to invest in our future, you invest in our students, K through M.D. and residency, actually. I don't see that attitude as strong as I'd like within our own Medical School. I think there's *fantastic* faculty, just *fantastic* faculty. I look at some of the names on the walls and it's been a privilege to even meet some of those. A guy like Paul [G.] Quie. Oh, my god! Is there a more emulatable human than Paul Quie? Ah! People like that and they're walking around. I did my graduate work here in psych. At that time psych was like second, third in the country, maybe even first. We had, I think, five current or former American Psychological Association presidents on our faculty. Every time I turned around, there was like one of the Nobel Laureates in psych. As a student, I could just sit around and talk to them. It was awesome [whispered]. The students here had that kind of faculty. Wow! [unclear] That's the crux. You didn't have them all over. The de-emphasis for the students, it's not so good.

Students are fun to work with, for gosh sakes. They're bright. They're inquisitive. They want to learn and they want to do better. Every one of our students on both campuses wants to make this a better world. What are we doing to foster that and push it? The D.J. [disc jockey] dances every year to fund raise for the MEDS project to send students to Panama or Costa Rica… These kids don't have a lot of money. So we'll raise some money that way. We'll have silent auctions. We have a lot of fun. Believe me, once you've dance with a student, it's a lot tougher to throw them out of med school. You work your butt off to make sure that they can, if they can, make it. I think that's the kind of quality faculty we've got in Duluth all over. That's what makes it fun, not that we're not frustrated every once in a while.

DT: [chuckles]

JB: I love going into work and I love going home. I couldn't ask for anything more. It's fun. I feel really blessed that I've been able to walk through this.

DT: That's wonderful.

JB: Come up and visit sometime. Really. If you're ever up in the area, stop by and I'll show you what a little dinky place it is. Diehl Hall is much larger than our Medical School.

DT: I actually came up to interview Alan Johns last month.

JB: Oh, okay, good. Then, you know how teeny it is.

DT: [chuckles] Yes.

JB: That's the end of the hall and that's the end of the hall. This is the in between.

Did that go well?

DT: It did, yes. He was wonderful.

JB: Isn't he a nice guy?

DT: He is super nice.

JB: He's a very nice man. Did you see the picture in the back hall of him in the first year?

DT: No, I didn't.

JB: There's a photo of the charter class on that thumb drive. Did I give it to you?

DT: No.

JB: Oh, I should have. I'm sorry. I thought I gave it to you.

DT: I said I didn't need the [unclear].

JB: I'll just email it to you.

DT: Okay.

JB: It's a fresh one of the very first class assembled for their class photo.

DT: Wonderful.

JB: There's pictures around of that, but this is a slightly different one. I think you can see some of the faces a little bit better and there's Alan. Granted he looks a *little* younger…

DT: [chuckles]

JB: …but not much. He's held up really well and, like I say, a nice man. He just got recently promoted to associate dean for whatever it is. I remember him as a student. That's a *sad* story. Ohhh, god almighty.

The farewell party for his class was truly memorable. It was at a community park. It was potluck. Faculty came and did some skits, made fun of each other and the students and all that kind of stuff. There were copious amounts of beer served. One of my recollections, not with Alan but with some of the other guys, is at the end of the night, I was the designated driver. I remember dropping off with a couple of other guys this one fellow who really had had way too much. So we somehow worked really hard to get him up on his front porch. He was not a light man. We set him down. We rang the doorbell and we ran like hell.

DT: [hearty laughter]

JB: I knew his wife and I did *not* want to see her that night. [laughter] Terrible. Terrible.

Like I say, once you start not just teaching and working with these fellas, but socializing with them, it makes for a much more fun culture and everything else. A lot of that is gone. It's much more formal now. Is that good or bad? Yes, it's good or bad. It's like everything else. We should have more parties, though. Parties are good.

DT: Well, thank you so much for the interview.

JB: Oh, it's a pleasure meeting you. Thank you for your good work.

[End of the Interview]

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