

## **Interview with Lyle French**

**Interviewed by Associate Dean Ann M. Pflaum  
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Lyle French - LF  
Ann Pflaum - AP

AP: Good morning.

What I want to start with, if you're willing, is just a little review for the record of your biography. I, of course, have looked into it and discovered that you were born in South Dakota, that you moved to Mankato for high school and, then, you went to Macalester College before entering the [University of Minnesota] Medical School in the late 1930s.

LF: In 1935.

AP: Could you tell us a little bit about more about your background, what led you to want to enter medicine, what it was like to be at Macalester, what your family was doing in Mankato? Then, we'll go on to a little bit about your medical school experience. Then, I'd like to touch on your experience in World War II and on into the time when you were a faculty member and an administrator. Would you be willing to give me sort of a brief bio in that way?

LF: I'll try and if you need something further, just interrupt me.

As you said, I was born out in South Dakota. We moved to Mankato, Minnesota, when I was about twelve years old. I went through high school there. In high school, I played basketball and golf, all the sports. I was president of both the junior and senior class of that school. The class size was about 225 students.

I went from there to Macalester College, basically on a basketball scholarship, although I got a certain amount of my tuition back because of having a certain grade point average that you could get at Macalester, at that time. I selected Macalester, in part, because of the scholarship but, in part, because I wanted to go to a smaller school rather than the university for my pre-med studies. I had decided, at that time, that, probably, I would take medicine as a life study, although I was a little bit uncertain.

I took the Medical College aptitude tests, which were about the first ones ever given. This was back in about 1933 or 1934. As a result of that, I got selected to go into the Medical School in 1935. I went through Medical School and finished in 1939. I interned at the University Hospital and came on as a resident in surgery and, then, in neurosurgery.

In 1941, I was called into the Armed Services because I had experience in neurosurgery and they needed neurosurgeons. This was before the Twenty-Sixth General Hospital was called into the service. I went down to O'Reily General Hospital in Springfield, Missouri, as the head of neurosurgery. When the Twenty-Sixth General Hospital, which is the University of Minnesota unit, was called out, I, then, joined them at Fort Sill, Oklahoma. We were there for a while before we went overseas. We went overseas to England and, then, across North Africa and Sicily and Italy, spending a little over three years overseas. During that time, I spent about half the time with the British forces because they were short on neurosurgeons and we had three neurosurgeons in the Twenty-Sixth General Hospital: Dr. Ritchie, Dr. Titrud, and myself. I was always very busy doing neurosurgery during all of this three and a half years overseas.

When I came back, I finished my residency and got a Master's and a Ph.D. in neurosurgery and came on the staff of the University Hospital in 1947.

AP: I want to follow up with a couple questions.

LF: Surely.

AP: First, is Ritchie, R-i-t-c-h-i-e?

LF: Yes, Wallace Ritchie. He's now expired: he's dead.

AP: Then, Titrud is?

LF: T-i-t-r-u-d, Leonard.

AP: Another question: What did your father and mother do that brought them from South Dakota to Mankato?

LF: Up to 1927, my father ran movie picture theaters in South Dakota. During the Depression period, beginning about 1927, he sold those and we moved to Mankato, mostly because my mother wanted to get out of South Dakota. [laughter] My father never did much work after that because he had a cardiac problem and was unable to do any work. The livelihood was made mostly by the boys. We were four boys in the family and we supported the family. The four boys, incidentally, supported their way through college and all four were in the military service.

AP: That's a very human story that you wouldn't find so much today, that kind of family responsibility.

LF: No, no. It was just the circumstances of having a fairly strong and persuasive mother and a father that just simply was physically unable to do anything.

AP: Had either of your parents had college?

LF: My dad had one year of college at Iowa State, in which he took courses in electricity, but that was way back.

AP: In the 1920s?

LF: At the turn of the century when there weren't many colleges.

AP: Can you say a little bit about your experiences overseas with the Twenty-Sixth General Hospital, which, of course, is the university's unit? Were there other doctors or was it exclusively manned and womanned by university doctors and nurses?

LF: The doctors and nurses were mainly from the University of Minnesota, but, also, there were a number of physicians from the Twin Cities. A fellow by the name of Borg, B-o-r-g, was the head of Internal Medicine. A fellow whose name escapes me right now was head of the Department of Surgery, although he shared that with a fellow by the name of John Paine, who was a professor of Surgery at the University of Minnesota. It was a combined Twin City unit, mainly from the University of Minnesota.

AP: Was that hard to get along with those people that you'd never...?

LF: Oh, it was not hard to get along with whoever it was. There was very close cooperation and close working relationships, at all times.

AP: Did you get good training?

LF: In the service?

AP: Yes.

LF: I had had a fair amount of neurosurgery before I went in so that I was competent to do most everything. When we went to England, I was assigned to the British head hospital—head of the body—which was a big unit in England taking care of all the head injuries and spine injuries for the British soldiers. I was assigned to them and I worked with them for a couple of months while we were in England. I learned a fair amount there. Then, when we went to North Africa and Italy, we were always busy. I was especially busy when I was attached to the British because they had a lot of casualties and very few physicians to take care of them. My experience in the Army really stood me in extremely good service when I got out of the Army. When I took my American boards in neurosurgery, they gave me credit for having spent time in the service. They gave me experience credit.

AP: Thank you. That's very interesting. You'll be interested to know that a large number of faculty members that we're interviewing had something similar. They had a significant opportunity in the service that gave them either administrative skills that they wouldn't have got or professional skills in some cases, like yourself, that might have been more difficult to come by.

LF: I think it was extremely valuable. I've never regretted one minute that I was in the service, even though I was married, at that time. My son was born the day I went overseas and I didn't see him until he was about three and a quarter years old. That was bad, but, nevertheless, the experience you got there, that at least, I did. I had a better experience than most people did. I was busier and had good units with which to work, so that I was comparatively well off in that regard. When I was with the British—and with the Americans, too—we were up close to the front, not with the Twenty-Sixth General Hospital. I was always reassigned to other hospitals because I was the youngest of these three neurosurgeons and I was put on detached service a great deal. For example, in the Italian campaign, when we were just north of Florence, we were a little bit under shellfire. One of my casualties was Bob Dole and I was the guy that operated on Bob Dole's shoulder when he was hit by gunfire.

AP: That's a wonderful story. That will be wonderful to use. Have you kept up with him?

LF: A little bit. I have some letters back and forth and that sort of thing. I have a copy of his book—but the book is no good. [laughter]

AP: Fast forwarding a little bit... You, then, came back to the United States. Was it in 1947?

LF: No, I came back to the United States in 1945 and finished my training. Because I had all this experience, there was no sense of my going back trying to learn more in neurosurgery, so I took neuropathology or pathology and got a Master's and, then, Ph.D. in pathology, writing mainly on brain tumors.

AP: You entered into the Department of Surgery as an assistant professor?

LF: I started in the Department of Surgery as an instructor in 1947. You had to start as an instructor in those days. You didn't jump. I was an instructor for about a year or a year and a half and, then, assistant professor for a couple years and, then, associate professor and, then, a full professor in 1955, or something like that.

AP: You headed that department for a while?

LF: I headed that department beginning in 1960 and stayed the head of the department until 1972. I took the job as vice-president in 1970. I was vice-president from 1970 until 1983. During that time, I still continued to do neurosurgery. I would do the first case of the morning at seven o'clock so that I was usually through surgery by the time Central Administration woke up and went to work—don't put that in. [laughter]

AP: I can believe that. That's a wonderful detail. I'll restrain...

LF: I really would do the first case in the morning and the nurses and anesthesiologists were always very good to me and let me do it early and get it out of the way.

AP: One of the things that you're credited with is having one of the most effective relationships with the legislature of any administrator in the university.

LF: Yes.

AP: The other thing that I think would be helpful for the readers of this book... Most people don't carry around in their head a very clear understanding of what an academic health center is or they don't have a very clear sense of the issues that health centers were facing.

LF: Let me expand on a couple of things. All units, schools for example, go up and down. They follow a sine wave. They have high times and low times. I don't care whether it's a school or a university, that changing wave for them is something that happens. The University of Minnesota, beginning right after the war or during the 1940s, was on the ascent of that wave because they had people like Owen Wangensteen, Cecil Watson, Maurice Visscher in Physiology, and Leo Rigler in Radiology, and others who were extremely good. During the 1940s, especially right after the war, certain individuals came back to finish their training or take training and they were very competent young men. As a result of that, the Medical School, especially—but this is also true to some extent of the other schools—became very proud and very, very good, being easily in the top ten medical schools in the country. That was because of the excellent faculty and also because of the students we had at that time. We continued that during the 1950s and the 1960s.

Then, in the early 1960s, we realized that the health care system was going to change. We realized that it was going to be more community care. The patients weren't going to be what we called horizontal, that is, in beds. There was going to be more ambulatory care. We also decided that there was going to be more coordinated care of patients between the physician and the dentist and the nurse and pharmacist and so on. We decided to try to develop a team effort in training our students to practice together when they finished medical school or finished nursing and pharmacy and so on. We decided to develop a curriculum that was entirely different than the one that we had had prior to, say, 1970. It was mostly to get a team effort education, a team effort so that the students would work together when they finished school. We developed programs in family practice. We developed the nurse clinicians. We developed pharmacy, what they called Pharm D students. You can find out more about that from [Lawrence] Larry Weaver. We coordinated their efforts in the care of patients. We were the first or close to the first school in the country that did this. In order to do it, we sort of put all these schools in the health area, such as Nursing, Pharmacy, Public Health, Dentistry, Medicine, Vet[erinary] Medicine, under the vice-president so that this could be coordinated and that's the job that I took.

We changed the curriculum at first and, then, we realized we needed new facilities because the old facilities were built sixty, seventy years earlier and they were outmoded for doing that and also they were outdated for doing up-to-date research. We decided to go to the legislature, through the university Regents, and build some new buildings in order to carry out this new curriculum and to get our students working together. It was fairly successful. We had good relationships with the legislature. We had a fair amount of integrity with them and credibility with them, much more credibility, basically, than the university as a whole, partly because the legislature realized what we were trying to do, and they also realized there was a shortage of health personnel. In the process, we almost doubled, not quite doubled, the number of health students during that period of time, during the 1970s. We did this with federal dollars, with some state dollars and some private dollars. There was always a combination of those three. Not any one of them was dominant. It was almost a third, a third, a third in the way we did it. Doing it that way, gave us a fair amount of credibility with the units that were giving money, the private, federal government and the state. We developed ambulatory care units, which were very early in the development of this concept, at the University of [Minnesota] at Duluth, for example. We helped to get the school going at the Mayo Clinic. They were only two-years schools at first. The Mayo Clinic, eventually, turned into a four-year school. We were able to get UM-D accredited because the Twin City school was willing to assume responsibility for the last two years of the training of the students. If we hadn't done that, we could not have gotten UM-D accredited.

AP: The new school opened in 1972, I believe?

LF: Yes.

AP: They're supposed to be training community practitioners. Neal Gault felt that that was very, very successful.

LF: It is a successful school. In order to get them accredited—I'm talking about a little different than just [unclear]—we had to guarantee that the students could come down the last two years and finish at the university in the Twin City area.

AP: The other thing I've been reading in press accounts is that there was some discussion of a medical school in St. Paul.

LF: There was a discussion of that. The state government did give them some money, but it was never even considered really by the federal accreditation units. It could never have gotten accredited because it wasn't organized with a strong faculty and it was kind of a slipshod way of trying to train doctors.

AP: So that Duluth was really the only viable one?

LF: Yes, that and the Mayo Clinic. The Mayo Clinic was under the University of Minnesota until 1983. That's when they separated away from the university.

AP: One of the things in reading Leonard Wilson's history about the Mayo Clinic... Apparently, it was a fairly controversial affiliation when the university went with them around 1915 or so...

LF: Yes, it was.

AP: ...in the sense that it was a group of private doctors so the university was affiliating with one group and not another. They were not the great Mayo Clinic that we know now. What was the explanation for the disaffiliation in 1983?

LF: The affiliation was that the Mayo Clinic would get recognition by the university as an educational unit, which would upgrade the Mayo Clinic. The doctors in private practice, not the university doctors but the doctors in private practice, objected to that. They did not want the Medical School to raise the standards of the Mayo Clinic because they were in competition. There was financial competition. So, consequently, when the affiliation was eventually done, it was not made with the Medical School but with the Graduate School so that the Mayo residents in training could get a Master's or even a Ph.D. through the Graduate School, but it was not with the Medical School, per se.

AP: Then, that Graduate School affiliation ended in 1983?

LF: That ended in 1983, yes.

AP: What was the reason for the ending of it?

LF: They simply wanted to have their own unit. Actually, they were under the vice-president of Health Sciences, at that time, and they were afraid that whoever took over my job wouldn't be as cooperative and helpful to them as I was. [laughter] They thought they were going to be better off if they tried to develop a separate unit and that's what they did.

AP: They give their own Ph.D.? Are they accredited?

LF: They could give, I think, their own Ph.D. now, yes. The M.D. that they gave was under the University of Minnesota, the aegis of the Regents of the university, up until that time.

AP: The records are littered with alphabet soup of the names of the new buildings and, then, sort of sagas of starting and stopping with construction. There would be a plan and they'd dig and, then, it wouldn't go forward. It must have been a very difficult time? You have so many buildings online after the Second World War, that it is just remarkable. Could you comment a little bit about that?

LF: We actually had a very integrated plan that we developed in the very early 1970s to build the units. The first unit was the so-called Unit A, which had to do with room for Dentistry, because they were very, very outmoded, and for some research units in the basic sciences. The basic sciences were for all the health sciences, at that time. That was why we started with building A, which is now Moos

Tower. Then, we had Unit BC, which was mostly Medical School. We simply needed that for room for the faculty. We increased the number of faculty because we had a great increase in students, not only in the Medical School but in Nursing and Pharmacy, the whole shooting match. We had no let-up in the construction. It went on, basically, as we had anticipated, all the way through.

AP: Okay.

LF: There was no real let-up. There's only so much we could build per unit time in that space because of the way buildings are constructed. You had to move people around and this sort of thing during the construction period. Then, we went ahead and did some delivery things over Unit K. Then, we built a new Nursing School, Nursing and Pharmacy together. Then, the last thing we did was the hospital. We made the hospital much smaller than we had before because we knew that patients were not going to be hospitalized for a week or two after surgery or after having pneumonia and so on. We knew that there would be more ambulatory care. That's why we made a fairly large ambulatory service and a comparatively small in-patient service.

AP: The other thing that strikes one as one looks at the Health Sciences Center is the very consistent cooperation with different private groups: the Variety Club [Heart Hospital], the Masonic groups. Is that common in other university hospitals?

LF: It's fairly common. We had good relationships with them. They understood what we were trying to do. We would go to their meetings. I would talk every week at one of these places, explaining what we were doing, why we had to do it, and so on. They were very cooperative and very, very helpful. The heart group, the Masonic... It went all the way across in every discipline. That was true in Medicine, in Dentistry, in Pharmacy, and Public Health and in Nursing.

AP: There were some—I think that was actually earlier—initiatives overseas to bring Minnesota medical expertise to different places. Neal Gault has told me about...

LF: Neal Gault was mainly involved in that. He went to Okinawa and to Japan and to Hawaii, where Hawaii had a medical school set up and he went over there to help them out. Those were the same sort of liaisons that we had also with Korea, the National Hospital in Korea. Those were the same sort of liaisons that the university had in Agriculture in Morocco and so on.

AP: The reason I'm bringing them up is I want to make sure that we include them in the story. I think it's an indicator of the eminence of the... Forestry, for example, was involved in Korea. Dentistry, I understand, trained most of the dentists in Saigon.

LF: Those things varied, not year to year, but for four or five years, depending on where the need was. I can't tell you, precisely, where they all went. Public Health was involved in many areas around the world. Ansele Keyes, for example, was a little before the time that you're talking about now, but he was also involved during that period.

AP: In fact, we have some quotes from him when he was in England doing some of his initial work on cholesterol.

LF: Those were programs that we had because you could do research. He did research on groups of people outside of the United States because he could get different health concerns in those units.

AP: Exactly, you'd get a more fluid profile.

Can I turn for a minute to a little more description of some of the personalities in the legislature that you worked with? I think one of the things that's an interesting story is just how the university worked with key legislators, went over to testify. Could you give us a little flavor of how that worked, who you worked with and talked with, and maybe some people that you admired?

LF: Beginning in about 1970, Stan Wenberg, W-e-n-b-e-r-g, was the contact with the legislature for the university. He was well liked over there by both the Democrats and the Republicans. Beginning in about 1970, the Republicans were in charge of most everything, but then, a little before 1980, the Democrats came into power. He was able to work with both groups. Then, Stan Kegler took over for him. Stan Kegler got along very well with both the House and the Senate and both the Republicans and the Democrats. They were very helpful in contacting [unclear].

I started presenting the Health Science budgets over there back in 1970. It was my job to get to know the leaders of that group Rod Searle, S-e-a-r-l-e, for example, and Roger Moe is one that came along. They were very, very good. They were very logical individuals. If you were able to explain to them what you needed, why you needed it, and you had credibility, that you hadn't fibbed to them in the past, they accepted it. That's why we did comparatively well over at the legislature because they accepted what we told them as being truth and they responded to that. We did a lot of contact with them. We'd have watches with them, and we would go over there and see them in between times, explaining what we needed to do, on an individual basis as well as on a committee basis. The individual contact, to some extent, was better. Now, I had an advantage over an awful lot of people that went over there because I had taken care of an awful lot of the legislators' families and they respected me.

AP: How did that happen?

LF: I was the physician for a lot of their families who were sick with head injuries or brain tumors or infectious processes or herniated discs and so on.

AP: You had both a medical relationship and a professional university relationship with them?

LF: Yes.

AP: I was going to turn to another subject, which, again, for the book is important, and that is for people to understand the... You started by saying that schools go up and schools go down.

LF: Yes, there's a real sign wave. The University of Minnesota, for example, during the 1940s, were in a crescendo and up through the 1950s. Then, in the 1960s, it kind of started to go down hill when Wangensteen got into his older age. Visscher was retiring. Watson retired. It kind of went down a little bit. It was helped by the selection of—you won't believe it—[Dr. John] Najarian. Because we had him, we got some other very good people: the head of Medicine, the head of Radiology, and so on. Najarian was a very strong character in the school. We also had a fellow by the name of Don Hastings, who was the head of Psychiatry, who was a real leader in the school. The school, then, started coming back up in the latter 1960s and early 1970s. We were very high during the 1970s and the first part of the 1980s.

AP: Was that the transplant business?

LF: It was because of a lot of things. We were going well in cardiology and doing cardiac work. We were doing transplants, at that time. We were doing a lot in brain research, in epilepsy and in brain tumors, and in vascular work, strokes and so on. So we got to be very well known. For example, my little Department of Neurosurgery got to be the foremost educational research unit in the United States. People don't realize that, but I can show you books written on it. It got to be the best that there was in the country.

Then, beginning about 1980, the thing kind of started going downhill again. That's the sign wave I'm talking about. When the faculty are comparatively young or middle aged, it goes up. When they get old, it goes down. Then they pick up new faculty and it goes up again. During the latter part of the 1980s, it went down. Of course, you think of it as the scandal of Najarian—that was part of it but not a great deal. You ought to talk to Najarian because he's really been a real leader in the health professions in the United States, frankly. I know the administration doesn't like him very well, but he's been a very, very strong person in the educational and research endeavors in the country for about twenty years. That doesn't strike you as much, does it?

AP: No, I've read that. In fact, I've talked with Cherie [Perlmutter]. It's going to be a tricky piece to write.

LF: I know that. I realize the problems you think he brought on to the university. If you took the view point of such as I, who was really out of the university at that time, and understood what the faculties were doing as far as research grants and so on, he wasn't doing anything that everybody else wasn't doing, not only in the Health Sciences but in History, or Physics, or Agriculture. They all did the same thing. He was criticized for doing certain things, but he had somebody from the NIH [National Institutes for Health] right on-board everyday approving of it—but it was always a verbal approval. I don't want to get into anymore than that.

AP: We are trying very conscientiously to capture that balance because, you're right, they didn't object at all. Then, all of a sudden, apparently...

LF: Because the administration in Washington changed. As soon as they changed personnel there, somebody suddenly said, "Whoops, whoops." That's what happens. I don't think we ought to get into anymore of that because I get a little peeved once in awhile.

AP: I don't blame you. We're trying very conscientiously to be...

LF: That's very nice. I'm glad you are.

AP: ...even-handed. Cherie told me, for example, that, to this day, Najarian still always gives a picnic for the freshmen.

LF: Oh, yes, no question about it. He's been a very excellent teacher. He does excellent research and I mean that. He's also saved, probably, more lives than anybody else in the country with that ALG [Antilymphocytic Globulin] over the years. It was used by every transplant surgeon in the world, almost. But it became very unpopular, in part, because drug companies saw that as a competitor and they wanted to get rid of the competition. Now there's a lot of innuendos here that I'm not going into. To some extent, the whole thing was tripped off by drug companies who want to do away with competition. I'm sure you're enough in the business world to understand that.

AP: That is a very interesting point. It is certainly a tragic time.

LF: Yes. The interesting thing is that a fellow like Najarian, during all this turmoil, did not lose the support of, say, transplant surgeons throughout the country. They thought what he was doing was not all that bad, you see. Of course, the President [Bill Clinton] has a lot of public support, too—except for Lyle French's. I'm talking about Clinton. [laughter]

AP: Uhhh, dear! That's another problem, a problem. Except for the sex, lies, and video tapes problem... Remember the gymnastics coach, that flap about eight to ten years ago? He took videos of himself having sex.

LF: Oh, yes, I read it in the paper.

AP: That's almost in the Clinton league of ridiculous.

Let me ask you: are there students or people in the Health Sciences that you think we ought to interview as we're going forward to capture this story?

LF: I said you should interview Najarian because he would give you a somewhat prejudiced but a very good interview.

AP: That's a good idea.

LF: You ought to talk to Cherie because she's been there for thirty years. I'm sure you probably have or are going to.

AP: Yes.

LF: Neal Gault, you've apparently already talked to?

AP: Right.

LF: Mellor Holland wrote a book on Dentistry [History of the University of Minnesota School of Dentistry].

AP: I've read that. That's a little too detailed.

LF: It's awful, frankly, but, nevertheless, it kind of gives you an overall summation of what they were trying to do.

AP: I'm going to try to talk with Dr. [Robert] Gorlin in the Dentistry area.

LF: Yes, I was going to give you Gorlin's name. Leonard Wilson in the history of Medicine wrote a book [Medical Revolution in Minnesota: A History of the University of Minnesota Medical School] on Wangensteen but it was such a prejudiced book that hardly anybody, other than Wangensteen, likes it. It really was just the history of Wangensteen's endeavors—which were very good.

AP: What about his history of the Medical School? Are you speaking of that or is that a different book? Leonard Wilson wrote a book on the UM Medical School. Is that the one you're referring to? He's got one that is a history of the whole school.

LF: It was a history of the whole school, mainly limited to surgery, as I remember it. I read the whole doggone thing. Leonard is a good guy to interview, that's what I'm saying.

AP: Paul Quie is one of our advisors, so he's helping us.

LF: Paul Quie was always overseas. Tell him I said that, will you?

[laughter]

AP: Okay.

LF: That's always been a little joke between Paul and myself. Every time I wanted him, he was in England or someplace. He would be a good person. I suppose [William] Krivit. I think the present dean of the Medical School would be a good person.

AP: That's Al Michael, right?

LF: Yes. You'd probably get a better view from him than you would any of the other pediatricians. There's a fellow by the name of [Eugene] Gedgaudas, G-e-d-g-a-u-d-a-s, who was head of Radiology for a long time. He knew what was going on. Larry Weaver, you should interview.

AP: From Pharmacy.

LF: He's part of the Pharm D thing. For Public Health, you should get a hold of Lee Stauffer. He's around someplace.

AP: That's a good idea. Nursing... did you work with Katharine Densford? She's a figure that seems to...

LF: I knew Katharine Densford quite well, yes, way back in the 1940s. But didn't Katie die?

AP: I think so. That's right.

LF: I think she just died a few years ago. I don't know who you would interview in Nursing.

AP: I've talked to [Sandra] Sandy Edwardson and she's given me some things. She's the current dean.

LF: She's been there continuously about as long as anybody. She's very levelheaded.

AP: I think part of the story is just to be able, in a few paragraphs with each of the fields, to give the reader an informed understanding of how they've changed in the last fifty years, to talk with each of the deans and to each of the people. For example, with the pharmacists, they are becoming much more of a health care partner than they were before, not just a dispenser of pills—that sort of saga.

LF: That's right, because of things like clinical pharmacy training programs, Pharm D programs and so on. The nurses are much more involved in the delivery of care than they ever were before.

AP: Right.

LF: They were strictly nurse to patient before and, now, nurses are coming into a whole array of activities.

AP: And there are some doctorally trained nurses, of course, which is an interesting story.

I wanted to ask you another question, Dr. French. If we were describing for our readers the University Medical School and we'll have the saga of the personalities, the major buildings, the changes in each of the fields, one of the questions that helps people understand *this* school is, How did it differ from some of the other medical schools that we might consider our peers? And who would we consider a peer if we were thinking about other medical schools?

LF: Other medical schools that are peers are the University of Michigan, for example, and I think the University of California at San Francisco would be a peer and the University of Alabama, probably.

AP: The one in Birmingham?

LF: Yes. The others are simply subsidiaries of Birmingham. They're like UM-D. Those are ones that you would consider as peers. There's a group of private schools like Duke, Harvard, Yale, but they do an entirely different type of training program than we do. They have much smaller classes. They're sort of oriented to some sort of research type of things rather than trying to put out a physician to take care of the community, to take care of people, as we are at the university. The university is a Land-Grant university and we need to respond to the needs of the people in the Upper Midwest. They've done this through doing excellent research and being able to develop community research institutions like Medtronics, as an example, and they've done it by developing community health care units, which we set up during the 1970s throughout the Twin City area. We developed a program in education out in the community where our students would go out for a year with the community doctors and community dentists, community pharmacists. We'd also bring those pharmacists in to study at the university for a period of time.

AP: Was that the Rural Physicians Associates?

LF: Yes. We also had Rural Dental, Rural Pharmacy, and we had programs in nursing, such as the so-called Agassiz in Northwestern Minnesota, programs where the nurses could upgrade themselves through getting a Master's degree without coming into the university.

AP: What should we say about Allied Health Professionals, which I assume is a new field after the Second World War?

LF: It's not a new field at all. Every...

[End of Tape 1, Side 1]

[Tape 1, Side 2]

LF: That's one of the things we did during the 1970s that was early on before any university.

AP: It's another rather populist kind of move. I can't imagine Harvard doing something like that.

LF: Well, they occasionally do it in a much more minor way. The University of Minnesota was always a well-rounded school, a very well rounded health area because we had all the disciplines. A lot of schools don't have nursing schools. A lot of them don't have pharmacy or dental schools. We had them all. We were able to coordinate our efforts and get help from, so-called, across campus. We got it from Physics, from the Engineering School, from Genetics, and Caldecott's School of...

AP: Biological Sciences.

LF: So we did gather in a lot of help from the university as a whole. I was always a firm believer in keeping the Health Sciences a component part of the university. Some people wanted the Health Sciences sort of separated out. I never thought that was smart at all. I thought the Health Sciences needed the university and the university was stronger with the Health Sciences as a component part I've expressed this lots of times to the faculty and so on, but never in an interview. [laughter]

We were early on in recognizing HMO [Health Maintenance Organizations] and the affect of an HMO on the delivery of care. We tried to integrate our educational processes so that our students were able to enter that changing health care mode.

AP: Another delicate issue has been the competition of the different hospitals and this sort of oversupply of hospital beds in the Twin Cities. Do you want to talk a little bit about the hospitals and the relationships with the other hospitals?

LF: Yes, I can. Back in the 1960s and 1970s, there was a shortage of health personnel and as a result of that, patients were oftentimes put in hospitals and kept there for a fairly long period of time, in part, because that was the best way to take care them. Then, as health personnel increased, nursing, pharmacy, medicine, and so on, there was more competition for patients and they were able to take care of patients without putting them into hospitals.

Incidentally, you ought to maybe contact Dave Preston.

AP: Oh, that's a good idea.

LF: Hospitals became competitive for patients and the hospitals would do everything—all the hospitals did this—in order to keep the number of patients they had and their economic status in good shape. One of the ways they could do that was to say, "We're part of the university system in that we're a teaching hospital and we do research." People respected that. Hospitals like Northwestern promulgated that very strongly. There were some other hospitals that did the same thing. Some of the hospitals, because they had dwindling patients, were phased out gradually. A few of the hospitals, like Northwestern for example, became very competitive with the university in trying to do the same things. They tried to develop a cardiac system, heart units, neuroscience units, and so on, in competition in order to draw patients in. They often were not very cooperative with the university. For example, when we wanted to renew the University Hospital, the only hospital administrator that came to our support was the Fairview Hospital administrator. He would go over and say, "You've got to support the university because it's the gem of the health care system in the state of Minnesota."

AP: Wasn't his name Carl Platou?

LF: Yes, Carl Platou. He was very, very supportive. The Fairview system has always been very supportive of the university, whereas Northwestern was highly competitive. They would like to do away with the University Hospital.

AP: That's kind of a *too bad* situation.

LF: It is, but it's partly because of the administration they had and, in part, just because of the economics of it. I can understand why. This problem was not unique to the Twin City area, to the University of Minnesota. It's been a problem in the state of Washington, in Seattle. It's been a problem in Portland. It's been a problem in San Diego, terrible problem in San Diego. It's been a problem at Harvard and in North Carolina at Winston-Salem and in Nashville. It's been a problem all over, so we're not unique in that regard.

AP: Let me ask you if there are other things you would like to share. I think one of the things that's most interesting for readers is what it really feels like to have had your responsibilities for the Health Sciences. Could you sleep at night? How in the world did you manage probably one of the biggest jobs in the world?

LF: [laughter] I don't know if it was the biggest job in the world, but I didn't have any trouble. If you've been a neurosurgeon, you've lived at a pretty high tension all your life. Consequently, to me, administration was comparatively easy. The thing that struck me, Ann, was—you can't put this in writing—...

AP: Okay.

LF: ...when I was working in the Medical School, everybody was working towards a common end. You've got common goals. We were trying to cure cancer. We were trying to cure infections. We were trying to help patients. When I moved over to administration, this was entirely different. I saw units living off another unit. If History had something or a group of people in History had it and the other group didn't, they wanted a share of it. It was an entirely different attitude, atmosphere. Consequently, when I was in administration and it got tough, I could just go back and work in the Medical School and operate and that feeling of why are you trying to live off me type of thing would dissipate.

AP: It's interesting. Most of the other administrators, when they go into administration don't go back to their professions. They stay administrators all of their lives, which is an interesting fact.

LF: I was never that pure an administrator. I also worked on a basis that the decision should not come from the top down but rather from the bottom up. I always figured that the person who knew the most about a situation was the person right on the land at that time, whether it was the guy sweeping the floor or the department head or the dean. It always seemed to me that the strength of a unit was not in the dean but rather in the department heads because it was the department heads that were doing the research. The department heads were doing the education. They were the ones that were selecting students, graduate students as well as undergraduates and that's where the strength of every school was. Now, having a good dean is very helpful, but Neal Gault will tell you that he had to have very strong department heads. To try to have a dean who can control everything and say, "You've got to do this; you've got to do that," is not a good system. For example, we had a dean by the name of Bob Howard. Do you remember him?

AP: Yes.

LF: He tried to control everything. The reason he got into trouble was that he tried to have a system where every patient that would come into the university would be kind of *his* patient and he could relegate where that patient would go and who would do what to whom. That just doesn't work. It doesn't work in a medical school, I can say that, or a nursing school, or dentistry, or any of those. Consequently, administration, to me, was comparatively easy. All I had to do was have good deans and all the deans had to do was have good department heads. I was responsible for their credibility, for their accountability and if they weren't doing their job, I could get on them and get them to do it. They recognized that and, therefore, worked very hard and were very cooperative. We had a very close relationship with our deans and the hospital director. Does that explain something to you?

AP: It does. It's very helpful and from knowing you and knowing what people say about you, it's one of those things that it is your leadership. I think you can take a great deal of credit for that.

LF: Yes, we did very well, frankly. We did absolutely everything we wanted to do and we did it on a fairly close timetable. We got curriculum changed, which was against the idea of a lot of the faculty, at that time. We developed a Family Practice Program, which a lot of the people in Internal Medicine thought was terrible and even some of the surgeons thought it was terrible. We got that done. We promoted Public Health so that they could do research and deliver care. A lot of people thought, why should Public Health people be doing that? We made Dentistry part of the health care team so that the oral dentists worked closely with the plastic surgeons, which we never did before. There was always competition with the otolaryngologist doing stuff on the face. We got them working together. We had a good relationship with the legislature. We usually had good relationships with the other individuals in administration. Once in awhile, we would run across an academic vice-president who was kind of jealous of the Health Sciences and who would try to put us down, but that was not the usual situation. I could tell you who they are if you'd want me to name them off.

AP: This is a public document. You get to decide whether you would like to name them.

LF: No, I would rather not. The longest term ones were very good.

AP: This has been extremely helpful, Lyle. Is there anything that I didn't ask that you would like to add?

LF: I didn't know what this was all going to be about, so I don't have much of notes or anything that would be of help.

AP: At least from my point of view, it's very complete and very helpful.

LF: The vice-presidents that were very helpful, of course, were guys like [Henry] Koffler. Koffler was very good and Bill [William G. "Jerry"] Shepherd was very helpful.

AP: Do you have any comments on the strength of the Graduate School? I think of Dean [Theodore] Blegen or Dean [Warren] Ibele. As you said, you would have had affiliations with them in the basic sciences.

LF: Yes, but we worked pretty independently of them.

One of the things that I did... We were, theoretically, in charge of all the promotions and monetary things of all the faculties and all the schools and I would spend every Saturday afternoon and all day Sunday going over documents such as promotion and tenure decisions during the time I was there. This was a very, very tedious and a very important task. I'm sure there's no vice-president that's ever done that since then.

AP: Yes, I hear you. Yes.

LF: I don't know; maybe they have, but I doubt it very much. Cherie was always helpful in this sort of thing if I couldn't make up my mind about something and so was Dave Preston. But I was the guy that would go over those things all day long. There were always a lot of them. I had a lot of trouble, at first, with the Mayo Clinic because they would send people up for promotions that we didn't think were ready for it. But they accepted our decisions and went with it. The Mayo Clinic was very cooperative with us.

AP: This has been very helpful. I am most grateful for your time.

LF: If you have any other questions sometime, give me a buzz, Ann. How are you doing?

AP: We're doing well. We've got a timetable. We have to have a draft ready by...

LF: I mean, how are you individually?

AP: I've had an interesting ten years. I left Morrill Hall in 1988.

LF: That's what I thought, yes.

AP: It was just before the whole Keller thing. I went over to University College, which is the Continuing Education and Extension and I'm associate dean over here. I've been in this job for about ten years. Right now, I'm spending most of time on this history project.

LF: In which college?

AP: It's called Continuing Education and Extension. It's Hal Miller's college.

LF: Oh, yes.

AP: Until this last year, we had Bard Gailey reporting to us. He has now gone back to reporting to the Medical School. It's a very nice outreach service unit, so I've learned a lot and enjoyed that a lot. Now, I'm spending time with Stanford Lemberg, who is in the History Department, working on this history. Clarke Chambers did about 130 interviews for about four years and, then, his health gave out. So, then, he and the administration recruited Lemberg and myself to finish the task.

LF: As I get to thinking about it, you ought to interview the people in the Minnesota Medical Foundation, not necessarily the one that's at the head of it now.

AP: Eivind Hoff, maybe?

LF: Not Eivind Hoff. Eivind wouldn't help at all, but the guy that was next, Dave Teslow, and also in the University Foundation, the guy that was a car salesman for a long time.

AP: Bob Odegard.

LF: You ought to interview those two. They might have been out of your scope a little bit.

AP: No. In fact, they are sponsors. The foundation, the Alumni Association, and the president's office are kind of commissioners of the study.

LF: Another name that knows an awful lot about the university is a fellow named Russ Bennett.

AP: Yes, Russ Bennett. In fact, we've a nice quote from him...

LF: Oh, you do. You're ahead of me.

AP: [unclear] working on the foundation but also his memories as a student shortly after the Second World War.

Do you have any thoughts about intercollegiate athletics?

LF: I think that intercollegiate athletics are a good thing for a university because they promote the university. I don't know that they are very good for promoting the individual. I think the university does athletics all right. I wish their teams were better, but I can understand the broad scope that they're trying to do rather than concentrating on only football or basketball or hockey—but I would like to stay out of that.

AP: [laughter] Okay.

LF: Well, I've just never been terribly involved. I knew Ozzie Cowells very well, but that was before your day even. He was the basketball coach.

AP: I thank you very much for your time.

LF: If you have any questions, just give me a buzz.

AP: Will do.

LF: If Sherry thinks what I've written is not any good, tell her to call me.

AP: [laughter] All right. Thank you very much. Have a nice day.

[End of Tape 1, Side 2]

[End of the Interview]

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