Nina Archabal

Interview with Joyce Funke

Interviewed by Professor Clarke A. Chambers
University of Minnesota

Interviewed on January 24, 1995
at the Home of Clarke A. Chambers

Joyce Funke - JF
Clarke A. Chambers - CAC

CAC: This is Clarke Chambers. I am interviewing, this afternoon, Tuesday, January 24, 1995, Dr. Joyce Funke, who was with the Boynton Health Service for a number of years. She received much of her medical training here at the University of Minnesota. It is part of the effort of the university and on my part to kind of fill in the informal history of the university. The formal reports tell us a great deal; but, how things really worked, we really don't understand very clearly.

Joyce, if you would start out by saying something about your youth. I gather it would be unusual for a young woman to be attracted to medicine—I know there were many, but it wasn't a majority kind of operation then—and what kind of encouragement you had and how you got sponsored, how you got into this profession.

JF: Although, I did go to medical school here, I grew up in Florida. I was born in Florida. My father was an architect in Palm Beach. As I was growing up, I was very involved in music; but, I loved math and I wanted to be an architect. My father thought that was not a proper profession for a woman. My father was an architect and I wanted to be an architect. He had been a professor. He graduated from the University of Wisconsin and taught at Clemson and at Georgia [Institute of] Tech[nology] before World War I. Then, after coming back from being overseas, he decided that he would prefer to practice architecture and, then, went to Florida in the boom years.

I went to Florida State College for Women. In those days, before World War II, the southern schools were segregated not only by race but also by sex . . . the state schools. I went there at sixteen and decided if I can't be an architect, maybe I'll be a medical technician.

CAC: You started at sixteen . . . you were precocious. That's early to start college.

JF: I had gone to school at five already knowing how to read—my mother had a preschool—and I skipped a grade; so, I got there early. In the middle of my sophomore year, I realized I was taking exactly the same courses as the pre-medical course. I went home that summer and told my parents that I was going to go on and become a doctor, not a medical technician. That was even worse, as far as my father was concerned. [laughter]

CAC: [laughter]

JF: He finally relented and we went on from there.

CAC: Did you have brothers and sisters?

JF: No, I was the only one . . . not for want of trying. I was the only one who survived, let's put it that way. When I was applying for med school—this was 1945-1946, my senior year in college—I was nineteen. I applied to Minnesota because mother was from St. Paul. She hadn't gone to the university; she went to Macalester. I thought that would be great if I could go to Minnesota. I applied to Wisconsin because of my father. I covered myself by applying to southern schools: Duke, Emory, and Tulane. There were no med schools in Florida, in those days. They had this archaic statute that no one could dissect a human body but a pathologist or a coroner.

CAC: Ah!

JF: Until they got rid of that, they never had any med schools.

CAC: That was the old fundamentalism from Bryan's days.

JF: That's right, yes. I got these replies from Minnesota and Wisconsin. [laughter] I sound like a feminist, but I'm not really. They said, "You're not a resident. You're not a veteran. You're female and you're young enough that you can apply again."

CAC: Ohhh.

JF: But, I was accepted at Duke, Emory, and Tulane. I went to Emory because my father had taught at Georgia Tech, and had gone overseas with an Emory unit, and said that's where I was going to go. I was there for two years. Then, there was attrition here at the Medical School and I transferred to the University of Minnesota between my sophomore and junior years.

CAC: Was it usual for people to transfer from one medical school to another after that length of time?

JF: Neal [Jr.] and Sarah Gault, my classmates, transferred from Baylor in Texas at the same time that I transferred. We became very close friends because of the fact that we were outsiders in

the class when we came in. No, it wasn't usual. We had a transfer from Harvard, actually, into our class.

CAC: This was into a class of what size when you got to Minnesota then . . . approximately?

JF: About 200, not quite. They were veterans, most of them. Some of them had been ASTP [Army Specialized Training Program] and B-12; so, they were younger. Both Neal and Sarah were veterans; they had been in the service. The majority of the class was older.

CAC: Did you have any expectation of the quality of the School of Medicine at Minnesota?

JF: Yes, because of its reputation.

CAC: As a young woman, you knew that . . . ?

JF: I knew that it was a good school. I have to say though that I was very unhappy for the first few months because of the difference in the type of teaching. At Emory, the class was only sixty. There was a very high faculty to student ratio. We never had an objective exam, fill in the blanks or multiple choice. It was either essay or oral. Then, I came up here and the exams were IBM multiple choice kind of stuff. [laughter] It was a different way of studying; but, I got used to it. In the end, I never regretted it.

CAC: Sure. You were still taking the basic disciplines?

JF: Oh, yes.

CAC: At what point, at that time in the 1940s, does one really get into medicine rather than biochemistry, and physiology, and anatomy, and so forth?

JF: In that era, you began actually in your sophomore year, both at Emory and up here, learning history taking, physical diagnosis, hands-on with the patient. I was lucky down at Emory in that I had Paul Beeson, who was a fabulous internist and later became the dean of the med school at Yale. He said, "I'm going to take all the women." In that class, there were fourteen women in the class of sixty.

CAC: That was unusual.

JF: That was very unusual. When I got up here, in this much larger class, there were four of us. [laughter]

CAC: Can you explain that? I would have thought that the south would have been slower..

JF: I don't know. Maybe there were just more veterans up here that survived. I continued here in my medical training and with a residency, internship, under the aegis of the university but at Minneapolis General Hospital. That finished my education as far as medicine is concerned.

CAC: Then, you had to go the internship or that was at General?

JF: That's what I'm talking about. When I graduated in 1950, they still had this old practice that you got a Bachelor of Medicine, an M.B. and, then, you had to intern for a year before you got an M.D. That was to assure that they at least had had some practice before going out as a G.P. [General Practitioner]. I had a year of internship and, then, I had three years of speciality training in internal medicine; so, four years post grad.

CAC: That was back at . . . ?

JF: That was at Minneapolis General Hospital.

CAC: I see.

JF: It was a university residency.

CAC: Supervised by . . . ?

JF: Supervised by the university, that's right. I was recruited, my last year at General, to go out to Montana.

CAC: Before we get to that, could you say a bit more about the internship there and the residency that followed? What was the nature of that at that time? These things change so from one . . .

JF: There were three kinds of internships available in medicine in those days. If you had made up your mind what speciality or what field of medicine you wished to continue in, you could take a straight internship and go on into your residency and spend less time in the residency, actually get credit toward the speciality requirements. If you weren't certain, you could take a mixed internship, which usually consisted of three months of medicine, three months of ped[iatrics], and three months of surgery, etcetera, or you could take a rotating internship, which once again, had three months in the major, surgery, medicine, and pediatrics, but lesser time in the other specialities like OB-GYN [Obstetrics-Gynecology], ENT [Ears, Nose, and Throat], etcetera. I took a rotating internship because I wasn't sure. I thought I wanted to be a pediatrician; but, I wasn't sure.

CAC: You were getting signals that way because you were a woman?

JF: Because I was a woman, yes. I didn't really like surgery. Of course, obstetrics and gynecology involves a fair amount of surgical procedures.

CAC: Sure.

JF: That's the other field that most women gravitated to in those days. I decided, let's get a rotating internship and see what I really feel best in.

CAC: You don't mind if I interrupt and turn this to a conversation?

JF: No, not at all.

CAC: I'm guessing that in the 1950s, where we are now, that the real heroes at Minnesota are your great surgeons?

JF: Absolutely.

CAC: Is that true generally in medical schools that the surgeons are kind of . . .

JF: They're always that . . . God incarnate, you know. [laughter]

CAC: Does it, therefore, attract that kind of person? Is there a self-selection of men that go into surgery?

JF: They have to be extremely secure in their abilities, I think.

CAC: And in their personality and character?

JF: And in their personality and their character. They're usually very strong people.

CAC: That's been my experience.

JF: Yes. There can be a surgeon who is fabulous and who is very sure of his abilities and, yet, can be a very gentle soul. We've had several at the university of that type.

CAC: [Owen] Wangensteen was a prevailing hero, was he not, at your time?

JF: That's right, when I was a medical student.

CAC: Did you work with Wangensteen?

JF: I scrubbed under him as a student, yes. It's one of the reasons I decided I didn't want to be a surgeon. [laughter]

CAC: He was an heroic surgeon.

JF: He was an heroic surgeon; but, he always had these long, long, long procedures because of the things that he was doing. That's very tiring to stand there, and just hold onto the retractor, and not get to do anything else.

CAC: But you get to, as a student at that point, observe great surgery?

JF: Oh, absolutely, absolutely.

CAC: Although it was a kind of surgery . . . I use the word heroic . . . it was more grand than surgery came to be later, right? Is that a lay person's . . . ?

JF: I don't think so. They were pioneers. Having done a lot of work in the dog labs, they were able to do procedures that had never been done before. I think that's not just true of Minnesota; it's true of other great teaching hospitals and teaching medical schools, too.

CAC: The great doctors train themselves with animal surgery on the way up?

JF: That's right, yes. When I was in this rotating internship, I found that in pediatrics, I was very uncomfortable with an extremely ill child. I couldn't be objective. I was crying with the parents and that doesn't help a bit. [laughter] I liked internal medicine very much and so that's what I ended up doing.

CAC: Paul Quie is a neighbor and friend and he said that he was an intern when you were a resident; but, was that during the pediatric part of the cycle?

JF: No, no, no. He was in a rotating internship also.

CAC: I see. That's where he ends up.

JF: Everybody at General took rotating internships in those days. I had a lot of future medical school faculty that I taught as a resident because it's a teaching function. People under you are your students. When I was chief resident there, I did a lot of teaching with the nursing students, too, because it was a three-year school. It was not affiliated with the university. They had their own teachers; but, I taught physiology and internal medicine.

CAC: What a good experience.

JF: Yes. That was lecture type teaching.

CAC: So, you were a teacher from the beginning? Would that be true at that time of doctors who went through a rotating internship?

JF: I was a resident then. I was a senior resident.

CAC: Okay. They would all have that experience?

JF: They would all have that.

CAC: Has that changed over the last forty years?

JF: I think so.

CAC: In what directions?

JF: As far as teaching the nurses is concerned, it's changed because you don't have the old hospital-based, RN [Registered Nurse] three-year programs. Nowadays, it's primarily a degree program in nursing. They have regular college or university affiliation. But, you're still teaching the medical students and the interns.

CAC: You were attracted to general medicine, internal medicine?

JF: Internal medicine. I wanted to be a cardiologist and I would have liked to have gone on into a fellowship, which they were just starting in 1954 when I finished. They were starting with the heart cath[eter] procedures and it wasn't long until C. Walton Lillihei and Dick Varco were doing the open heart surgery, etcetera; but, I was broke. I didn't have any money; so, I went out to practice.

CAC: It's a long haul, isn't it?

JF: Yes.

CAC: Then, or now?

JF: Yes.

CAC: I hear so many horror stories that doctors tell about their early internship and residency of working twenty hours a day and six days a week. Was that your experience?

JF: Yes. As an intern, I made $25 a month. My last year as a resident, I made $120 a month. We were on call every third night, which meant thirty-six hours of duty every third day. Yes.

CAC: We'll get to Minnesota and the Health Service . . .

JF: Eventually.

CAC: I'm just interested in medical education. This was the rule around the countryside? Minnesota was no different?

JF: That's right.

CAC: Was it thought that this was in some way initiating or socializing the intern or the resident to a guild or a profession? What justification can you make for that kind of exploitation?

JF: I can't say what happened at the University Hospital, but I think they had similar experiences. At General, of course, it was a city hospital and there were only so many residents in each field; therefore, the hours had to be filled.

CAC: There were doctors after all.

JF: The attending physicians were primarily private physicians from downtown that came and made rounds. There were a few full-time attending . . .

CAC: Staff doctors?

JF: Staff doctors . . . but not many.

CAC: How do you remember that experience? It went on for three of four years.

JF: I was young enough that it really . . .

CAC: You had the energy then?

JF: I could fall asleep like that [snap of the fingers] and wake up like that [snap of the fingers.].

CAC: Okay.

JF: You learned to get your sleep when you could. If it's a catnap for thirty minutes, fine. [laughter]

CAC: It's a crowded learning, right?

JF: Yes. Yes. The only thing that I really regret about that period was that I didn't have as much time to read as I would have liked to, to keep up with the literature. It was hard. We did have conferences, etcetera. We had to do journal reviews and so forth, but still it wasn't a real, real academic setting, in that you had time to leisurely study because you were working too hard.

CAC: You finish your residency and, you were about to say that you took a position in Montana.

JF: I was recruited by a lovely gentleman. I was the first female internist in eastern Montana and the only internist for 110 mile radius. [laughter]

CAC: What town was that?

JS: Glendive, Montana. Glendive was a cattle town, a wheat town, and a railroad town. It was the headquarters of the Yellowstone Division of the NP, the Northern Pacific. The hospital was a Northern Pacific Hospital; so, if you practiced there, you automatically were also a railroad doctor. We had all the railroad men from Billings and Laurel [Montana] west to Bismarck and Mandan [North Dakota] east.

CAC: Does this mean that you had a specialized patient load then?

JF: About 10 percent of the patients that we saw were railroad. The rest were the people . . .

CAC: What percent of those would have been accidents rather than other . . . ?

JF: I didn't see the trauma. I just did internal medicine.

CAC: That's right. I understand.

JF: Although, on occasion, if I were in the ER [Emergency Room] and somebody came in with a scalp laceration, I would sew them up—which is against union rules in internal medicine, but I did it anyway. [laughter] I enjoyed the four years there. I just got tired of the fact that the laboratories were inadequate. We had no radiologist. We had to be our own radiologists. I had to do GI [gastrointestinal] series and barium enemas with very little training, a very short course in radiology, with an old open cathode ray tube that every time I stepped on the switch, it went snap! crackle! pop! [laughter] Scary. The patients were scared, too.

CAC: I bet. Now, you can have that barium enema and you can watch it on the screen . . . the patient can.

JF: Yes. I did all the postmortems because I'd had extra time on pathology with E. T. Bell between . . .

CAC: In a way, that's really a post residency. You were still doing a large number of things other than just merely general or internal medicine.

JF: I had six months with John [Ira] Coe.

CAC: I don't know him.

JF: You don't know John Coe?

CAC: No.

JF: He was the head of pathology at Minneapolis General and the first true medical examiner in Hennepin County. I liked path, too, but I like living people better. [laughter]

CAC: You're still learning.

JF: That's right.

CAC: You're there four years. Then, you come back to the Twin Cities?

JF: I come back to the Twin Cities. My mother wanted me to come home; so, I came back—my parents were divorced in 1947 and that's another reason for the move up here—I was glad that I did it. I came here in January of 1958 and began my work at the Health Service at that time . . . January 1, 1958.

CAC: Did the Health Service seek persons to come or you sought them out?

JF: They were looking for someone in internal medicine. They had one internist at that time, Dr. Stella Sikkema, who had been there since 1950, I believe. They needed more help; so, I was recruited again and I came back to the cities.

CAC: That kind of practice appealed to you as distinguished from a private practice which you would have several [unclear] and so forth? To work with students . . . was this any kind of attraction?

JF: When I came, I told Dr. Ruth Boynton, who was the director at that time, that I was not certain that this was going to be my permanent aim in medicine and that it looked like it would be an interesting position, but that I wanted to just try it out and see how it went. She said that was fine. [sigh] I was interviewed by another very pioneer woman physician, Dr. Olga Hanson, who was at the Nicollet Clinic and who was married at one time to Dr. [Jennings] Litzenberg who was the head of OB-GYN over here. They wanted me to come to the Nicollet Clinic. By that time, I had been at the Health Service for about six months and I decided I really liked this because I liked the students as patients. I liked the faculty as patients. They were intelligent. They were compliant.

CAC: The faculty compliant? [laughter]

JF: Mostly. [laughter]

CAC: All right.

JF: It was a wonderful patient mix.

CAC: Roughly what proportion were students and what proportion were faculty or staff?

JF: Because I saw people primarily be referral, I saw probably more faculty than others.

CAC: Because the troubles . . . students don't have that range of problems?

JF: They do. Some of my fellow physicians say, "How can you take just being there at the—quote—Student Health Service, almost denigrating its importance. I said, "I have seen more pathology in this student body than I saw in the four years that I was out in Glendive. I was seeing young people with Hodgkin's [disease], with leukemia, with very serious infections, with congenital heart disease. In the 1950s and 1960s, before a lot of investigation was done by pediatricians and close monitoring of young people, they didn't go to doctors that much. I found atrial septal defects, and ventricular septal defects, and coarctations of the aorta, and all this kind of stuff.

CAC: I see.

JF: It was just fascinating. It wasn't boring at all. I wasn't just seeing infectious mono[nucleosis].

CAC: That never would have occurred to me that the incoming generation and the level of practice would have changed to that degree by that time.

JF: It changed a lot.

CAC: More people are going to doctors? The demand increases?

JF: That's right. I never saw a doctor as a child unless something happened to me, an injury. We didn't go for regular checkups.

CAC: Was there a women's clinic at that time?

JF: Oh, yes. We had a gynecologist, Dr. [Helen] Haberer who was very beloved and very good. At that time, there was only the one gynecologist. Then, we got a couple more and, now, it's a very large clinic, of course, including nurse practitioners practicing gynecology.

CAC: Just to follow that up very briefly. Did they follow through and deliver children?

JF: No.

CAC: That was by referral?

JF: By referral.

CAC: I'm guessing that probably those of you who were primary care had to do a certain amount of counseling with female students who were upset and anxious about what had happened?

JF: Oh, yes. Of course, this was pre-Roe [versus Wade], too.

CAC: Could you share something of that, then?

JF: There was such a difference in the 1950s and 1960s in what we could tell the young person.

CAC: Ethically, or legally . . . or medically?

JF: Both. In order words, there was no such thing as a legal abortion.

CAC: Yes.

JF: So, that our counseling had to be, Do you want to stay home? Do you want to go someplace else and have this child? Are you going to put it up for adoption? It was hard, really hard.

CAC: It must have been.

JF: Yes. The birth control pills, of course, came in during the time that I was there and that solved a lot of the problems.

CAC: With the Health Service, when does the pill really become generally available for distribution to students?

JF: To the student body . . . as soon as it was approved.

CAC: And that is what year? It's early 1960s?

JF: Around 1960, 1961. I'm not sure so don't . . . approximately.

CAC: Then, the sexual revolution, so-called . . .

JF: What happened, of course, was the sexual revolution.

CAC: So you get a real demand.

JF: We had a big demand for it. We had the tremendous increase in sexually transmitted diseases.

CAC: I'll bet.

JF: That's when the women's clinic became much larger. We had a wonderful public health nurse . . . actually two of them in succession, who were very good in counseling the young people, also. They took care of a lot of this.

CAC: There was no legal or ethical problem in providing pill contraceptives for minor, young women under eighteen or under twenty?

JF: There may have been but they received them anyway. [laughter]

CAC: It was policy of Boynton's?

JF: It was policy of Boynton to do so, yes.

CAC: Policies like that . . . once the pill came, you had to have a policy on how you were going to handle it?

JF: That's right.

CAC: After Roe, you'd have to have policy on referrals for abortion?

JF: That's right.

CAC: How were policies like that made? By what group of people?

JF: We had, of course, always an administrative council and committee that consisted of the directors . . . the director, the associate director, the assistant director, the health educator, the public health nurse.

CAC: These people were there by their office?

JF: That's right. We would sit there and we would discuss this. Some of this went to the regents for decision, believe it or not.

CAC: Tell me about that.

JF: I can't remember the exact date, but it was discussed at a regents meeting as to whether or not it would be approved if we dispensed birth control pills, particularly to minors.

CAC: When it was taken to the regents, was it with an affirming recommendation from . . . ?

JF: The Health Service.

CAC: But, you needed that kind of higher support?

JF: Approval . . . that's right.

CAC: I assume that it came then?

JF: Yes. I should backtrack and say that in the 1950s . . . It must have been after 1961 before we were giving the birth control pills because Dr. [Ruth] Boynton was there until 1961. She was very, very adamantly opposed that would cause parental displeasure. For instance, she would not allow the meds and interns that we were training on Station 48 to do pelvics on the female students. We had to have a consent from the parent to do a pelvic on any young woman under eighteen.

CAC: This may be a good point just to say a few things about Ruth Boyton. The Health Service carries her name and you knew her personally.

JF: I knew here very well.

CAC: She was a towering figure. Could you add to what we know?

JF: She had been director of the Health Service for some twenty-two years when I first met her. She had succeeded Harold Diehl who had been the director before her. There were only two directors prior to Ruth Boynton. There was a Dr. John Sundwall who was the first director. The Health Service was established in 1918 by order of the regents and President Marian [LeRoy] Burton. Then, Dr. Harold Diehl became the director of the Health Service in 1921 and remained the director until he became dean of the Medical School in 1936.

CAC: This is the Diehl of Diehl Hall?

JF: That's right, the Diehl of Diehl Hall. Ruth Boynton served for twenty-five years as director.

CAC: Would it have been usual in the country to have a female head of Health Services?

JF: She was the only one. What did they say about the Health Services?

> By 1947, the Health Service achieved a long list of firsts, bests, and mosts as reported in *Sky-U-Mah*. It offered the most complete and comprehensive medical care of any health service in the country. It was the largest in staff and number of people served in the country. It was the first to require a manitou test for tuberculosis in routine physical exams and to X-ray those who tested positive. It was the first student health service to require a Wassermann test for syphilis in routine physical exams. It was the only co-educational health service directed by a woman. The fee paid by the students for its services was one of the lowest.

CAC: What document are you reading from there?

JF: I'm reading from "A Brief History of Boynton Health Service;" but, it also is a quotation from a history of the Medical School and the Health Service that was written by Dr. J. Arthur Myers.

CAC: So, people really wanting to go into it can find these documents?

JF: That's right.

CAC: That's quite a statement. I assume it's reasonably accurate or entirely accurate.

JF: Yes.

CAC: How do you account for that? Why should Minnesota have been ahead of the curve, as we say now?

JF: I think a lot of it had to do with both Dr. Harold Diehl and Dr. Boyton, in that they felt that student health was something that had been neglected in the Nineteenth Century and that there were a tremendous number of problems with infectious diseases, and epidemics, and so forth on university campuses. The very first year that they the Health Service, they had the influenza epidemic of 1918.

CAC: Oh, of course.

JF: They had some 2,000 plus cases that they cared for and several deaths. They kept having those problems and so the Health Service not only served as a medical care facility but also became a Department of Public Health for the campuses.

CAC: I see. Was this the model elsewhere also or did Diehl really . . . ?

JF: I think Diehl really pushed for that. It became actually the Health Department. The university became a separate entity, like a city in and of itself.

CAC: That's interesting.

JF: The Health Service was policing all of the health problems and pushing smallpox vaccinations because they had a smallpox epidemic twice in the early years.

CAC: It was financed from 1920 to 1950 out of student fees?

JF: That's right. It's still financed out of student fees.

CAC: Entirely?

JF: Mostly.

CAC: Is there any other source of income at all? Now, of course, you get insurance for your private patients?

JF: Although, there aren't private patients really.

CAC: Retired persons like myself . . . I have Medicare and Group Health.

JF: Okay. That's right, you get that. I guess there are some that have outside insurance, too. The students are primarily paying fees which, of course, have gone from three dollars a year to quite a bit per quarter. I don't have the exact fee. I'd have to find out.

CAC: When I came here in 1951, I was urged to join it. I think I paid $100 a year for all outpatient care. I tell you, that was a bargain. That lasted a long time.

JF: It started in 1930 that the faculty health plan was devised, that you could pre-pay for your medical care . . . for all outpatient care not for inpatient care.

CAC: Yes.

JF: Initially, the student fees covered inpatient care for the students also. We had our own hospital ward.

CAC: I didn't know that.

JF: Oh, yes . . . Station 48 and 49. Station 48 was the general medicine ward and Station 49 was contagion.

CAC: That wasn't linked to the University Hospital?

JF: Yes, it was. The whole north wing of the University Hospital was built by student fees.

CAC: Ahhh.

JF: What later became North Clinic and Medicine Clinic was initially the third or fourth Health Service. Then, Station 48 and 49, and then 58 and 59 . . . all of that was built by student fees. The first Health Service in 1918 . . . they didn't have any place to put the Health Service; so, they used two fraternity buildings on University Avenue. The frats were closed down because the boys were all overseas. Then, they moved into the basement of Pillsbury [Hall]. Then, they had a temporary building for awhile where the current Health Service building is. Then, they

built his north wing of the University Hospital and also had a temporary across the street where Diehl Hall is now, where they had mental health. Then, they built the one on the west side of Church Street and it has, since, been enlarged.

CAC: When did they give up inpatient hospital care?

JF: In the late 1970s.

CAC: Why would that decision be made? Why did the university withdraw from hospitalization?

JF: Because it was not financially tenable anymore.

CAC: It was not a medical decision.

JF: No. I'm trying to think . . . was it in the 1970s or was it in the early 1980s?

CAC: That's another decision that this group you're talking about have to make as a matter of Health Service policy?

JF: That's right. Probably around the latter of 1970s . . .

CAC: Okay. People who really want to trace that down can. It's a financial decision. How then do students cover their hospitalization if they have to?

JF: They have insurance policies, which they take and they cover not only themselves but they can cover their dependents, etcetera.

CAC: Is this optional? Students can take it or not?

JF: They're not supposed to be enrolled without hospital insurance.

CAC: That's a condition to the health fee.

JF: Some of them lie about it. Then, they get into real trouble when they have a serious illness. They supposedly can't get clearance over in the [unclear] office unless they have evidence of having hospitalization.

CAC: By that time, the university has a hospital insurance program for its faculty so they're covered that way.

JF: That's right.

CAC: By the mid 1970s, it's all by referral?

JF: That's right.

CAC: There's also referral here, I'm guessing, for speciality clinics? I'm leading up to a question about the relationship of the Medical School, and the hospital staff at the university, and the Health Service and what that relationship was and how it changed.

JF: The Medical School faculty were actually involved in both student and faculty care over at the Health Service from the 1930s, I believe. As the Health Service grew, there were specialty clinics established and they were manned by the various faculty members from the Medical School . . . for instance, the Surgery Clinic, the Ears, Nose and Throat Clinic, the Orthopedic Clinic.

CAC: They'd come over one afternoon a week or something of that sort in rotation?

JF: In rotation, that's right. The Surgery Clinic met everyday and so did most of the specialty clinics except for the smaller ones like ENT, etcetera.

CAC: Internists and residents are being used for this, too?

JF: Not interns and usually not first-year residents. If they were manning the clinic, they had to have a senior attending faculty person overseeing what was going on.

CAC: Then, how did the financing of that work . . . the professors who were coming over?

JF: The Health Service gave a certain amount of monies to each department.

CAC: I see . . . by contract? Then, they were expected to cover the clinics?

JF: That's right.

CAC: You as an internist would make, then, referral to the proper clinic, if necessary.

JF: If necessary.

CAC: And others, as well? What's the size when you're there in the 1950s and 1960s of the regular full-time staff in Boynton itself?

JF: We had thirty-two, I think, full-time physicians that were not from the Medical School. [Looking for document] I should have this all in my head . . .

CAC: Oh, no.

JF: . . . but I don't.

CAC: I'm just really seeking for approximate figures of what the size of the staff might have been.

JF: [Reading from document] "The staff of the Health Service increased from one full-time and one part-time position in 1918 to thirty-one physicians." This is 1928. Then, by 1947, they had more full-time physicians. The thirty-one were mostly part-time, eight of them full-time.

CAC: There's a substantial permanent staff.

JF: It's not just physicians, of course. It's all the nurses, the medical technicians, our technologists, the pharmacists, the whole Department of Environmental Health and Safety, which was a huge endeavor and all started . . .

CAC: That's in Boynton, too?

JF: That's all in Boynton.

CAC: And still is?

JF: I think it has separated since. Initially, they always had a sanitary engineer who did the inspection of the swimming pools, and the dormitories, and the food service; but, when they started to have a lot of radiation, and radioisotopes, and other things that had to be monitored, they had to have physicists and radiation engineers and all of this to supervise what was going on. The Environmental Health Department actually had the authority, for instance, to shut down the Division of Nuclear Medicine.

[End of Tape 1, Side 1]

[Tape 1, Side 2]

CAC: . . . I'm inquiring about the staff, thirty or forty full-time professional staff, of medical doctors. Can one describe the general characteristics of that cadre of doctors? Were they motivated differently from persons who would be in private clinics with six doctors, or in private practice, or associated with a hospital? Does Health Service practice attract a different kind of medical doctor?

JF: It certainly attracted one who was not necessarily interested in making a lot of money. The salaries were not magnificent and still aren't. They improved over the years; but, of course, so did inflation. I would say they were probably individuals who enjoyed a more relaxed form of medical practice where they didn't feel that they were pressed to see sixty-five or seventy patients in a day—which happens, believe it or not downtown because of the almighty dollar. Therefore,

I think that the students and the faculty both had a much more rewarding experience with the physician in the Health Service than they might have had in a very, very busy private practitioner's office.

CAC: Correspondingly, less stressful?

JF: Less stressful. I also have to say that one of the things that we always emphasized was that the student's time and the faculty's time was as valuable as ours; and, therefore, we should pay attention to the fact that they were sitting out in the waiting room and they might be due for an exam in a certain period of time and they had to get there or the faculty person had to give a lecture. We weren't clock watchers, but we were trying very hard to keep to a schedule. Very few times, did one of my patients, for instance, have to wait more than fifteen to twenty minutes and, mostly, it was maybe five unless I had an emergency because their time was important.

CAC: I can report as a patient for forty years there—still am—that I had much better service in that regard, but also a higher level than the rest of my family who had to go to busy clinics and wait for an hour or two for the appointment they had. I never had that experience. If I had something . . . a sprained ankle . . . I could come in and by god! I was with a doctor in three minutes.

JF: I think also that a lot of the physicians, and certainly myself, felt that we had a two-fold duty to our patient. That was not only to take care of him medically but to educate him on what was wrong with him, and why, and what he could do to prevent a recurrence, and what he could do to maintain a better health standard from then on.

CAC: You had the elbow room in your practice to play that educator role?

JF: That's right.

CAC: That is appealing.

JF: It is. Plus, we had the clientele that could understand what we were saying. [laughter]

CAC: [laughter] Which would not have been true in eastern Montana to the same degree?

JF: Not to the same degree.

CAC: I suspect you may have had a certain number of patients who read up before they came.

JF: True. True. They were very primed with questions and arguments.

CAC: Partly primed to diagnose themselves.

JF: Eastern Montana . . . I didn't mention that while I was there, Glendive grew from 8,000 to about 20,000 because of the oil boom. We were swamped! We didn't have much time to do educating and talking. There were only six physicians in our group. We were the only doctors in town. We were busy. I had a luxury when I got to Health Service. I was very comfortable with having more time to talk to the patient.

CAC: Can you estimate . . . what was your patient load in the 1960s, just for example, on a given day?

JF: It would depend upon whether they were a lot of new patients because I usually tried to have at least forty minutes for a new patient or if there were a lot of returns, which would be maybe ten minutes, fifteen. If you figure out an eight hour day, you can determine how it would work out.

CAC: Okay. To get to you, we couldn't walk in, initially, and ask for Dr. Funke?

JF: The faculty had the power to do that, to self-refer. The students did not.

CAC: I see. I had the power only because the dean of my college said, "You better go to Joyce Funke."

JF: [laughter]

CAC: I don't know whether he wrote or called ahead, but that's how I got to you.

JF: Was that "Easy" [E.W. Ziebarth]?

CAC: No, Frank Sorauf.

JF: I go back to "Easy." He was my patient for thirty years.

CAC: "Easy" is going to move into the condominium.

JF: Here?

CAC: Yes, he just bought an apartment over in the other wing.

JF: Oh, really?

CAC: Yes. When you go to supper tonight, you'll see all kinds of former patients.

JF: I know, that's why I don't live here. [laughter]

CAC: [laughter] It's a long enough time. It would be safe for you to come. Do you think?

JF: Not really. I still get phone calls.

CAC: I see.

JF: If I were right in-house . . .

CAC: I suppose that's true. We have a former member of the Boynton staff.

JF: Ted Watson?

CAC: Yes.

JF: He was a gynecologist, of course.

CAC: He helps informally a lot of folks in his wing.

JF: Yes, I'm sure he does.

CAC: He doesn't think of this as a burden and he doesn't intrude. In emergencies, he's really saved a lot of people just being there.

JF: I'm sure. Ted's a gentle soul, too.

CAC: Yes, indeed.

JF: He's very sweet. Jean [Mrs. Watson] is a lovely person, too.

CAC: Just to take him as an illustration. He came into Boynton late in his career, I think, because he wanted to get out of a stressful private practice.

JF: He didn't want to do surgery anymore and he didn't want to deliver babies anymore.

CAC: There would be a certain number of your staff who were of that sort?

JF: Actually, it was true more in the 1950s, 1960s, and early 1970s that there were a number of the staff that used it as a bridge between a very heavy, busy practice and retirement. Then, we tried to push for younger physicians that would make it a lifelong career. The staff gradually got younger and younger in the 1970s and 1980s.

CAC: Can you estimate—I know you don't have figures—what kind of turnover there would be by decade of the doctors? Did they churn and leave?

JF: I was there for almost thirty-one years . . . Hugh Thompson for much longer than that. There were a number that stayed and made it their lifelong career.

CAC: Which meant that it was, as you were reporting it, a very rewarding career for a certain kind of doctor who didn't want to become a millionaire and to take the stress and the hours that that involved?

JF: That's right. Since I had, for a number of years, more of an inpatient practice than any of the others or more of an ongoing inpatient practice, I had more night calls, and more weekend visits, and rounds, and so forth.

CAC: That was part of your regular responsibility?

JF: That was part of my regular responsibility. From 1963 to 1967, I was the permanent attending consultant in internal medicine on the inpatient service teaching the Department of Medicine interns. They were straight interns in internal medicine, but they were assigned to the Health Service inpatient ward for a rotating period of a couple months per intern. That was a teaching thing that was permanent and they would call me and I'd come over. The general physicians, in the general outpatient clinic, would rotate through that service for a three month's period and, then, the rest of the year, they were not there. They had three months where they had to make hospital rounds, but not the other nine months. Mine was more of an ongoing thing.

CAC: At that time, the hospital rounds were just across the street?

JF: That's right, yes. Then, later, of course, we had our fifth floor completed into an inpatient service at the Health Service. If you took the elevator up to five, it used to be a hospital ward with forty-eight beds.

CAC: I see.

JF: Then, we had family practice residents to teach up there. That was fun.

CAC: That raises a sideways question of the speciality called Family Practice. The University of Minnesota initiated that roughly . . . or did you always have a family practice specialty?

JF: No, no. It was initiated, I think, probably during the 1960s.

CAC: Was this a national . . . ?

JF: It was a national thing. The feeling was that the old model of general practice where a person would go to medical school for four years and, then, have a one-year internship, possibly a year of surgery, or a year, of OB or whatever, and go out and call themselves a general practitioner was an inadequate period of training to be out in [unclear] practice for instance. The

model of family practitioner evolved in which these young people would have their four years of medical school and, then, they would have a three-year residency in family practice where they would spend a certain period of time in each of the specialities so that they could be a real well-rounded person in the practice of general medicine. Not only that, but they have their own speciality board. Just as I had to take the American Board of Internal Medicine specialty exams, oral and written, and be certified as a *diplomate* of the American Board of Internal Medicine, they have an American Board of Family Practice and they have to take boards before they can be certified as a family practitioner. They are one of the few boards that requires, absolutely requires, recertification. Every seven years, they have to take the boards again. In many of the other boards, it's elective whether you go back and take them over and over. A family practitioner is a much better doctor than the old G.P. because he's better trained.

CAC: Yet, what I have seen in the Twin Cities—I try to read background for some of this—is that from 1960 to 1990, the attraction of specialty for young doctors was very tempting, very seductive. Did the family practice attract a substantial number of persons when it started in the 1960s and 1970s?

JF: No, it did not.

CAC: Why not because it seems to me there is a real need there?

JF: Because the specialties and particularly the surgical specialties were more glamorous and more lucrative. You don't find many family practitioners that are making $300,000 a year, for instance. You certainly don't find any Health Service physicians that make that kind of money. I think that there has been a concerted effort at the University of Minnesota to increase the number of young people who are going into some phase of primary care medicine, not just family practice but general internal medicine . . . pediatrics. At Duluth, for instance, the Medical School is so geared that about 40 percent of their students are going to be family practitioners. They have a preceptorship type of program at Duluth and they also have it here where the medical student can rotate through a nine-month period, actually with a family practitioner out in rural Minnesota, for instance. It can count toward their four years of medical school.

CAC: This would be a chief justification for Duluth opening up a second medical school? There was opposition to that.

JF: Yes, that was one of the main reasons, plus the fact that the Duluth physicians felt, Why not? [laughter] We're pretty good teachers, too.

CAC: It's a political . . .

JF: Yes, it's a political thing.

CAC: We see, the last two, or three, or four years, a national move to accelerate that strategy again, don't we? We talk about case managers. Is that a new name for an old thing?

JF: Yes. Actually, it's a new name for what we used to call a gatekeeper and we still call it that in the HMO [Health Maintenance Organization] practice.

CAC: In a way, you were a gatekeeper at Boynton.

JF: I was.

CAC: You did a lot of the work yourself, but then in referral, you were a gatekeeper.

JF: That's right. I could make a decision . . .

CAC: I don't mean only you but your colleagues as well.

JF: That's right. Minnesota was a pioneer in HMO, Health Maintenance Organizations, but the Health Service was an HMO long before Group Health because it was a group of individuals who had pre-paid medical care, total pre-paid. All of their medical care, including inpatient care was initially pre-paid by the student fee; so, it was a model of an HMO way back to 1917. [laughter]

CAC: How does the university maintain accountability of a health service, that is, how can they maintain its quality? Does the university itself play a supervisory role in any way?

JF: I think only indirectly. The Health Service has, from the beginning of the availability of accrediting organizations, subjected itself to accreditation examination by national committees. You know that hospitals, for instance, are accredited by a group of people who come around and examine the records, and the practice, and the death statistics, and all of that. The same thing is true of outpatient clinics now. The Health Service has, from the very beginning, subjected itself to that national type of accreditation. We have quality assessment committees.

CAC: Does the Medical School itself provide any kind of supervisory role historically for the Health Service?

JF: I think probably in the beginning it did . . . not so much now. It's more of cooperative role than a supervisory role.

CAC: Okay. I'm kind of pressing on this point because I found, talking with people on both sides of Washington Avenue—I hadn't realized what a chasm, what a canyon Washington Avenue is—that the Health Sciences have a degree of autonomy from the university and I was trying to get a sense of how . . . Boynton was really autonomous, too?

JF: Yes, although, practically any great . . .

CAC: Except for going to the regents per [unclear] policy.

JF: That's right, regential approval of this, that, and the other was always necessary.

CAC: But, only on really major ethical . . . ?

JF: For expenditures, and new changes in financing, and all that kind of stuff. But, in terms of the quality of medical care, the regents, I don't think . . .

CAC: Not only the regents . . . I'm talking about the vice-presidents and Morrill Hall, as we say.

JF: Okay. The vice-president of Student Affairs does have a supervisory and an authoritative type of . . .

CAC: Oh, good. That is exercised in what ways?

JF: First of all, in the appointment of the director now.

CAC: Oh, I didn't know that.

JF: Oh, yes. They have to approve the findings of the search committees, etcetera. Also, in decision making in various parts of the workings of the Health Service, they are involved directly . . .

CAC: The kinds of services?

JF: The kinds of services, etcetera . . . in the approval of what goes on between the Health Service and the Student Fees Committee.

CAC: That's your link . . . the vice-president for Student Affairs?

JF: That's right.

CAC: That helps clarify a problem.

JF: You'll notice, if you look at my CV [Curriculum Vitae], that although my faculty position was in the Department of Medicine, I actually achieved my tenure through the vice-president of Student Affairs.

CAC: I see.

JF: Don't ask me why, but that's the way it went.

CAC: These tapes sometimes illicit things that you can't find from any kind of report or document. You don't know how these things work.

JF: Yes.

CAC: The setting of the student fee is done in cooperation with Boynton?

JF: In cooperation with Boynton. The directors and the administrators, etcetera, at the Health Service, figure out a budget and propose student fee levels. Then, this has to go through a Student Fee Committee.

CAC: On which students are represented?

JF: On which students are the prime representative, plus the vice-president of the Office of Student Affairs. It's a lot of bargaining.

CAC: But not the vice-president for Health Sciences?

JF: No, but that may change, of course, now that we have a provo[st]. I don't know.

CAC: Historians can't worry about the future.

JF: No. [laughter]

[break in the interview]

JF: I should say that one of the other things that we had at Health Service was a continuing program of Continuing Medical Education [CME].

CAC: Good!

JF: We had staff meetings every week, which consisted of an hour of lectures or discussion of certain problems in various fields of medicine. Many of the programs were given by the Health Service staff themselves; but, many were also given by consultants from the Medical School or by outside medical experts who were willing to come and talk to us about a particular topic. We had a good program going and it was approved by the Division of Continuing Education for CME credits toward our medical licensure.

CAC: Ah!

JF: For the last twenty years or so, Minnesota has required that a physician have a certain number of CME credits per year to . . .

CAC: You say CME. What is that?

JF: Continuing Medical Education . . . to maintain their license. If you're in a speciality, you have to have more than if you're a general practitioner.

CAC: You can do that in-house through Boynton?

JF: In-house through Boynton, plus, of course, if you're teaching, you get hours of credit for the hours that you're teaching, as well. They assume that you must be being educated by your students as well as doing the opposite. [laughter]

CAC: A doing a little homework as well.

JF: That's what I loved about teaching. As far as the house staff was concerned, if you didn't keep ahead of them . . . boy! it was embarrassing; so, you had to study.

CAC: You use the word education as part of the primary medical responsibility. Does this mean preventive?

JF: Both.

CAC: Does Boynton get into preventive medicine in a group way?

JF: Yes, they have courses which they put on over in all of the resident's halls about various . . . in the old days they'd call it personal hygiene, tips on health maintenance. They have a cadre of students who become volunteers and who serve as peer counselors for other students in various fields such as prevention of sexually transmitted diseases and birth control.

CAC: Was that a new initiative in the 1960s or has that been around a long time?

JF: That's been around for quite awhile.

CAC: And it remains active?

JF: It remains very active.

CAC: I can't imagine a similar model elsewhere in clinical or private practice.

JF: No, I don't think so. Boynton was a pioneer in having a Department of Health Education. In 1954, Ruth Boynton hired Dr. Edward Dvorak who had a Ph.D, in health education. That was the beginning really, in the 1950s I think, of getting these student groups together.

CAC: Does this reach out to the dormitories for example?

JF: Yes.

CAC: You have to train these peer advisers in some way or educate them?

JF: That's right.

CAC: Is that done at other student health centers around the country?

JF: I think it depends upon the size of the school.

CAC: It works better in a large school?

JF: It works better in large schools. I don't think that a small private college with a student body of 2,000, for instance, would have anything this formal; but, I think you see it in a number of the Big Ten schools. You would see it in a school such as Harvard or Johns Hopkins.

CAC: Is there a national association of student health centers?

JF: Yes. That goes back. The first director of the health service was one of the first officers in what was called the American Student Health Association, but is now the American College Health Association.

CAC: Staff members go to regular conferences?

JF: Staff members go to meetings. There is a North Central Division of the American College Health Association, which involves, primarily, Big Ten people, and other colleges, and smaller private schools in this area. A lot of those meetings are held at Minnesota but they may be down at Michigan or . . .

CAC: You keep in touch with what other schools are doing?

JF: Yes.

CAC: This means that once this really has authority, that Health Centers are more similar than they're dissimilar?

JF: That's right.

CAC: There's a real melding of this. When does Boynton take on in a serious way psychiatric work for students or faculty? I have a sense that it increases. Is that not right?

JF: The number of physicians and psychologists has increased, of course; but, they've always had someone full-time in mental health since the 1930s.

CAC: So, it's not a new focus or concentration?

JF: It's not a new focus at all, no. Bob Hinckley and . . .

CAC: Not even in size? I was just guessing that there would be more demand for psychiatric . . .

JF: In size, yes, it has gradually increased. At one point, they had one full-time psychiatrist and they had one psychiatric social worker. Now, they have four full-time psychiatrists. They have clinical psychologists. They have psychiatric social workers. It's a department in and of itself. The whole north fourth floor is the Mental Health Clinic.

CAC: Does this say anything about the student body or does it say something about the medical profession that this would be expanded in that way?

JF: I think students are more inclined to accept counseling and psychiatric care. There's no longer a stigma about seeing a psychiatrist. In fact, for some, I think it's a status symbol. "I saw my shrink yesterday and he said . . . " [laughter]

CAC: Yes. [laughter]

JF: I think it's much more acceptable in the general public.

CAC: Then, Boynton has to meet that demand?

JF: That's right.

CAC: Do you have anyone in geriatric medicine? I'm thinking that there are only retired professors who would need access. Most of your clientele are youth.

JF: The internal medicine people are the ones that take care of the geriatrics.

CAC: Once in awhile, when I go over there, I see old timers there.

JF: Oh, yes. I had many patients that were in their eighties and nineties when I was there. That's not so bad.

CAC: There's an eye clinic. It's a full service.

JF: That's right. The eye clinic has changed in that we always had an ophthalmologist in the past. Now, we have an optometrist and we also have refraction technicians. If it's something that requires ophthalmological surgery, it's referred across the way.

CAC: I had that experience with my left eye.

JF: What kind of experience was that?

CAC: It's degeneration of the macula in that eye. You were the one of the ones that caught it originally twelve years ago.

I guess I'm feeling my way toward some concluding questions here regarding morale of staff or how they related to each other. Was there a real sense of being engaged in a common enterprise or whether the specialities are separating and fragmenting in the Health Service?

JF: I have to say that the morale I think was better early on when I was at the Health Service. That is because medical practice, in general, was easier. Now, with all the changing economic factors in medicine, I think, that it's a much more stressful situation at the Health Service as well.

CAC: As everywhere?

JF: It's a matter of making contractual arrangements with outside HMOs, which some of the students already belong to. There are all kinds of factors that make it more difficult. It seems to me that the camaraderie that was there in the 1950s, 1960s, 1970s, and 1980s is not quite the same.

CAC: You attribute that to some of the factors you talked about just now?

JF: That's right.

CAC: What else is happening? I ask that because I find—as we were talking over tea—that so many of the people I've talked with, forty or fifty of them, report that that's true also in their discipline wherever it is in the university. There's kind of a separation . . . a kind of loneliness.

JF: It seems to me that they don't have as much time to just sit and talk to one another over the luncheon. We brown bagged it because we didn't have time; so, we'd all sit down in a lunchroom, and we'd sit, and we'd chat. Those that didn't have an appointment at one o'clock might even play a few hands of bridge. You don't see that anymore because it's go, go, go, go.

CAC: That's medical practice, but it's also physics, and philosophy, and agronomy?

JF: Yes. There was a lot of love among that staff early on.

CAC: When that sense of being part of a common enterprise is lost, then, there's also a loss of fellowship and as you use the word love?

JF: That's right.

CAC: Or caring for each other?

JF: Yes. They are more a group of individuals than a melting pot of good friends and colleagues, it seems.

CAC: That's what I hear everywhere. Being an historian—all historians are skeptical; that's the first quality they must have—I attribute some of that to a kind of nostalgia. Oh, when I was young . . . when I was beginning practice. You think objectively that's . . .

JF: I think that's the case. It has changed.

CAC: It is the pressure of high-tech medicine and the pressure of more forms and the administrative problems are more complicated when you have to refer people out rather than just across the street or to a fellow [physician]?

JF: Yes.

CAC: All those things operate?

JF: Their budget really is a bare bones budget, too. They can't push the student fees to the point where they could have all the luxuries that they used to have.

CAC: It's not been able to keep up with the inflation in medical costs . . .

JF: No.

CAC: . . . which, as you know, is faster than the general inflation?

JF: Yes. Maybe I shouldn't say this, but I think that there was a period, particularly in the last four or five years, where there was a feeling that the administration really didn't have that same caring. The director who is no longer there was a different type of individual. He was a driving kind of fellow who wanted for us to see more patients per hour than they had been. That didn't help. I don't know what it's going to be now. They have a new director who is a physician, but primarily in public health. That is his background; so, we'll see.

CAC: I find that reflective of the colleges and university generally. There is a division. The access to deans, vice-presidents, and presidents, for example, is less.

JF: Yes.

CAC: The administrative burdens on the province, that is the departments, is far more severe than it was twenty-five years ago and, in part, because of litigation. Now, was there a developing problem of medical litigation in Boynton?

JF: We had a few episodes, primarily in gynecology, I might add. I think that reflected the tenure of the times with the sexual revolution and all the problems that were going on.

CAC: You'd be sued for what reasons or what causes?

JF: Actually, the individual physician was sued for providing services that they felt were not correct or something. I had forty years of medical practice and never had a malpractice suit. That's why I retired . . . to get out while I was ahead. [laughter]

CAC: [laughter]

JF: Of course, the Health Service provided the malpractice insurance for the staff. That was covered. It was one of the benefits.

CAC: Other clinics could not say the same thing the last forty years? Some of their partners have been sued?

JF: Sure. I think that the surgical specialties are . . .

CAC: Yes, more vulnerable.

JF: Anybody doing invasive procedures is more vulnerable . . . and trauma, etcetera.

CAC: I see. There's no emergency ward? One could get in with a sprained ankle.

JF: There is an urgent care area. People can walk in.

CAC: With a gun wound?

JF: With a gun wound, with a heart attack or whatever. They are given triage and, then, transported over to the hospital. We can have people where we have Code Blue for instance, cardiac arrest. Now, they've got their own defibrillators and [unclear] and know how to use them.

CAC: We've covered lots of subjects, and it's really very engaging, and it helps me to understand much better and whoever listens to it, I'm sure. Are there any ultimate reflections you would like to add before we turn this machine off?

JF: No, just that I think it was a wonderful thirty years at the Health Service. I really enjoyed it.

CAC: Your identification is not with the university but with the Health Service?

JF: No, no, no, no. I enjoyed the teaching that I did across the street as well.

CAC: Of course.

JF: But, I think in terms of interaction, and friendship, and so forth, it was primarily Health Service. I have many friends in the Department of Medicine that are of my vintage and some of them very close friends and some faculty members in the Medical School; but, it wasn't quite the same as the daily interaction at the Health Service.

CAC: I'm very grateful for your service of thirty-one years and for sharing it. I'm sure that people that listen to this will be enlightened as I am. Thank you very much.

JF: You're welcome.

[End of Tape 1, Side 2]

[End of the Interview]

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