

Robert Ulstrom, MD

Narrator

Dominique A. Tobbell, Ph.D.

Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

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

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

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

Biographical Sketch

Robert Ulstrom was born in Minneapolis, Minnesota, on February 23, 1923. He attended the University of Minnesota for his undergraduate and medical education, receiving his BS in 1943 and his MD in 1946. He completed his internship and residency in pediatrics at Strong Memorial Hospital in Rochester, New York. From 1948-50, he served in the Army Medical Corps. He then returned to the University of Minnesota as an instructor in the Department of Pediatrics in 1950 and was promoted to Assistant Professor in 1952. From 1953-1956, he worked in the Department of Pediatrics at the University of California, Los Angeles. He returned to the Department of Pediatrics at the University of Minnesota in 1956 as Associate Professor. In 1961, he was promoted to Professor and became the acting chair of the Department of Pediatrics. In 1964, he returned to UCLA as the chairman of the Department of Pediatrics. He returned to the University of Minnesota in 1966 as Associate Dean and Professor of Pediatrics. He retired from the dean's office in 1970 and returned to the Department of Pediatrics. He retired from the University of Minnesota in 1990.

Interview Abstract

Robert Ulstrom begins the interview by describing his background, including his education, his service in the US Army, and why he became a pediatrician. He reflects on his mentor Irvine McQuarrie, and his colleagues John Anderson, Robert Howard, and Lyle French. He discusses his experiences in University of Minnesota Medical School, his move to UCLA, his return to the University of Minnesota in the mid-1950s, and his work as associate dean in the College of Medical Sciences. Other topics discussed include, his research, the private practice issue, relations with affiliated hospitals and their faculty after the expansion of the Medical School class size in the 1960s, the curriculum revision in the 1960s, the attempt to establish a medical school in St. Paul, the establishment of the Department of Family Practice, tensions between private practice physicians and Medical School physicians, the effort to establish a Minneapolis children's hospital in the 1960s, tensions between Minneapolis and St. Paul physicians, the reorganization of the health sciences into the Academic Health Center in 1970, the Mayo Clinic and the Mayo School of Medicine

Interview with Robert A. Ulstrom

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at Doctor Ulstrom's Home

Interviewed on February 18, 2010

Robert Ulstrom - RU
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Robert Ulstrom. It is February 18, 2010. We are speaking at Doctor Ulstrom's home at 4616 Sunset Ridge in Minneapolis.

Thank you, Doctor Ulstrom, for letting me speak with you today.

RU: I'm honored, and it's my pleasure.

DT: Good.

To get us started, tell me a little bit about your background, where you were born and raised, and how you came to practice medicine.

RU: I was born and raised in Minneapolis, the northern part of Minneapolis, and graduated from North High School. I went directly to the University of Minnesota for pre med. I never thought I would be able to get into Medical School. Even toward the last of it, I didn't think my academic record in pre med was up to what the others were, but I got in without any waiting.

This was during World War II. Within about one academic quarter, which was the spring quarter, we medical students had to go into one of the Armed Services, but we would stay in school and continue our education. I joined the Army. The Army paid a small salary and gave us our meals and our books and our tuition, so it was kind of like having the

same set up as people who came back from active duty and went to universities with very little expense.

Then, after I finished the University of Minnesota, the man who had become my... I'm looking for a word that would be more descriptive than just a friend. He was the head of the department and my role model and my helper. At that time, to go into an internship, you had to know somebody there. He had spent part of his career at the University of Rochester, New York, so he talked with them, and I ended up going there, which was a great thing. They had a wonderful hospital set up and a great Department of Pediatrics. I was able to spend two years *not* in the Army there but as a civilian. Of course, they didn't pay me when I went there. The war-time system that allowed me to be there had cut the amount of time in medical school down to three years from four, and the internships were cut to nine months instead of twelve. I had a second full year after the internship at Rochester, all in pediatrics.

Then, I had to go on active duty in the Army. I spent two years as a commissioned officer at two different general hospitals, the large hospitals of the Army. One of them was in this country in the State of Washington and the other one in Frankfurt, Germany. So I had a wonderful opportunity with about fifteen months in Germany of seeing a lot of Western Europe at the time.

Then, as my assignment came to an end, I had an offer from both Rochester and the University of Minnesota to come and finish my training, and I chose to come to Minnesota. I was, very shortly after arriving, given a faculty appointment as instructor. I thought I was going to be hurting for money, but the instructors were paid more than the Army captain's wages. By then, I was married and we had our first child, a daughter [Jane] She was born about a year before we went to Frankfurt, Germany. When we came back, she was learning how to talk at that time but she had a German accent.

[chuckles]

RU: We had a woman the Army provided to help my wife [Mary] with the household duties. One of the things she did was she took to our daughter, and did a lot of teaching her German language.

I don't know how much more you want me to go on here, but that's kind of how I got started.

DT: That's a good start, and I'll have some follow up questions. First of all, do you recall the name of your role model, mentor, who was the head of Pediatrics at the University of Minnesota.

RU: Yes. Doctor Irvine, I-r-v-i-n-e, McQuarrie.

DT: Ah!

RU: He was the professor of Pediatrics at Minnesota, head of the department over a twenty- or twenty-two-year... There are a lot of mementos of him left around.

DT: Yes.

What do you recall about your experiences in Medical School? Were there any particular memories you have of the various faculty members teaching and lecturing?

RU: Yes. I thought the approach of Minnesota faculty was really first class as far as demanding of the students without creating feedback that was unfavorable. The whole country really recognized that; although, there are no formal rankings, I always was told by people from other medical schools that Minnesota was one of the best. That's what I thought, too.

DT: Are there any particularly memorable faculty in terms of their teaching abilities or how they taught? Anyone that stands out?

RU: Well, Doctor McQuarrie was one of them. Sort of on the other end of the spectrum—I don't think I'll give you his name—was the head of Ob-Gyn [Obstetrics and Gynecology] Department. [Doctor John L. McKelvey] Everybody considered they would stay out of his way so he wouldn't see them personally...

[chuckles]

RU: ...because he was very demanding far beyond what most medical students could enjoy. There were other teachers that were already world renowned and doing good teaching. Owen Wangenstein, professor of Surgery was one of them. Cecil [J.] Watson, the head of Internal Medicine was another one. Some of the subspecialties had people like that, too, but most of them were not working full time at the University then. They were in private practice and they just gave their time and covered ophthalmology, otolaryngology, allergy, things like that. We got to know those people who were, if nothing, the leading physicians in their specialties around the Twin City area.

DT: After you finished your residency, you were an instructor at the University of Minnesota, and you worked in that department for about three years. Is that right?

RU: Yes, that is right. Three years.

In the third year, I was promoted to assistant professor. I had made friends with Doctor McQuarrie's vice president, I guess you might call him. His name was Doctor John Adams. John had gone to be the first head of pediatrics at the new medical school in Los Angeles, which was part of UCLA [University of California, Los Angeles]. He had taken a couple of people from the Minnesota faculty with him, another one named Adams [Forrest Adams]. He found out that I was doing well at Minnesota. After I'd been there about three years, while Doctor McQuarrie was on a teaching mission in South America,

John Adams convinced me Dr. McQuarrie wouldn't injure me when he came back if I signed up to go to UCLA—so I did.

DT: [chuckles]

RU: I was out there for about three years, at that time.

When Doctor John Anderson was made head of the department to succeed Doctor McQuarrie who retired, I knew John Anderson from going to pediatric meetings around the country. He was professor, most of the time when I saw him this way, at Stanford University Medical School, which, at that time, was in San Francisco...the medical school was. Shortly after that, when another Minnesotan took over after Doctor Anderson came to Minnesota, that man went on to become head of their pediatric department and then as dean of their medical school. So it brings out the role Doctor McQuarrie played not just with me but I was one of a large number of people who were trained, to some degree, at Minnesota who, then, went and were heads of departments and brought more honors to Minnesota for things they did after they left Minnesota.

DT: Why was it you went into pediatrics? Was it because you had built a good relationship with Doctor McQuarrie?

RU: That was part of it, but I've always liked little kids. While I was in Medical School, for example, there was a little girl that lived at the other end of the block from where I lived, and she used to come and knock at my parents' house, at the door, and she would want to see me. So when I got into Medical School, she was about three years old. When I came home which was on weekends only, because of the Army business, she knew when I'd be home, and she'd come down. I'd try to be studying and she'd be in talking with me.

DT: [chuckles]

RU: That's one of the examples of my like for little kids. Doctor McQuarrie just made it that much easier for me to follow through on that.

DT: Going back again to when you were at UCLA... You came back to the University around 1956?

RU: Yes.

DT: What prompted you to return?

RU: Well, Doctor John Anderson was taking over as head of the department, and he and I had talked, before he actually moved here, about the need for dividing things into subspecialties.

Doctor McQuarrie had really never done that; although, cardiology had been established by another Minnesota faculty member, whose name was Paul Dwan, D-w-a-n. Paul Dwan was the son of one of the founders of 3M [John Dwan] and had tons of money and used it to start the cardiology section of the department. He was a Harvard Medical School graduate and had a lot of training in cardiology and radiology before he came back to Minnesota. He grew up here but he was gone getting training in Boston for quite a long time. He, also, had a downtown practice when he returned to Minnesota.

Once I really got a taste of pediatric medicine, I never would think about going into any other part of medicine. That followed through as I gained more in the way of responsibility for things in the department that took me away from the clinical part of it. But I always was able to maintain a part of my activities there as seeing pediatric patients. In the process of that, I set up a section on endocrinology and metabolism that didn't exist before that.

DT: So that was really your subspecialty focus?

RU: Yes.

DT: What was it like then working for Doctor Anderson?

RU: It was very different. Doctor McQuarrie was the gentle giant and Doctor Anderson was the clever administrator. He was chosen very appropriately because he'd had so much experience with having to raise the money to do anything in the department. The University wasn't doing much that way, and Pediatrics never had the kind of income that it has now that could be invested for continuing to explore things in research, private practice and teaching and so forth. I think it's most everybody's opinion that Dr. McQuarrie was well liked but he was not likely to be any one person's good friend. He was friendly but people were more in awe of him than they were just friendly. John Anderson was the other way around. He had friends all over the pediatric world. He had the knack of raising money or saving money so that he could pay much better salaries than Doctor McQuarrie could and was willing to follow the trends of general pediatrics in departments around the country and that was to break off into just certain subspecialties. Now, I think there are ten or twelve subspecialties that have the privilege to have sub-boards and board certification. Endocrinology is one of them.

DT: Were you doing research as well as practice?

RU: Yes. Right from the beginning, it was my idea that I would be at a university because I wanted to do research. I had emphasized biochemistry in pre med, and it was along those lines that I wanted to follow up on some clinical studies that had gone on, so most of the studies all through my career that I was involved in were in some aspect of endocrinology or metabolic diseases. I always had a lab that I supported by mainly money from the National Institutes of Health. That was one of the ways that, after I had spent three years with Doctor John Adams, Doctor Anderson could entice me here. The laboratory facilities that he was offering was part of the way he got along generally with

the administration, and he was able to find rooms when the hospital had expanded that could be biochemical laboratories.

DT: When you came back and you were working in the Department of Pediatrics with Doctor Anderson, Doctor Bob Howard was appointed dean of the College of Medical Sciences. Do you remember anything about that transition and how faculty responded to Doctor Howard being the new dean?

RU: Yes, I do. I knew Doctor Howard before that, because we were in the same medical fraternity. We weren't close friends, but I knew him pretty well. The man he succeeded was Harold Diehl. Bob Howard was quite a bit younger than Harold Diehl, who, actually, retired. At that time, the University rule was at sixty-five all faculty had to retire.

DT: Yes.

RU: I think a lot of faculty were kind of disappointed because they were hoping more for another father figure like Doctor Diehl was. But he [Dean Howard] was very friendly with almost everybody. But as time went on, he got out of friendliness with a group of people who actually were threatened that they were going to have to give the school some of the money they earned in private practice while also having a full-time faculty appointment. They didn't want to do that. That problem stayed with him all the time until he no longer was dean.

DT: Do you recall the names of some of the faculty who were threatened by Doctor Howard?

RU: Yes, they were Doctor [Lyle] French, Doctor [Richard] Varco... The head of Psychiatry, what was his name?

DT: It wasn't A.B. Baker, was it?

RU: No, he wasn't around

DT: He was in Neurology. Hastings?

RU: Don Hastings, yes. They were all powerful in their own departments. Hastings wasn't a surgeon type but I guess all the rest of them were in one part of surgery or the man who was head of Anesthesiology, Fred... [Frederick Van Bergen] [pause] Then there was a man who was head of Urology [C. D. Creevy] who probably had the highest income, and he just stayed clear. He got to retirement age and retired. He never joined in with the attempts to divert Bob Howard from the direction he was trying to head in. He never really was able to get that operational.

Dr. Howard did a lot of good things, too. I think his collaboration with John Anderson and some of the other department heads that didn't really have access to private practice

money to amount to anything...he would help them find the money that they needed to do things. John Anderson brought in, oh, I don't know how many total faculty members in the time that he was head of the department, but the department went from having half a dozen or less faculty members—now, I'm talking about full time faculty members—on up to in the neighborhood of a hundred. You say, "What did they all do?" Well, things were found for them to do and places to do it. So it was done very rationally.

DT: What was your attitude towards the faculty practice issue?

RU: Well, I thought the methodology that was being used by Bob Howard was never going to go any place. Whereas, I didn't want to be recognized as being in one school or another, I could see that schools around the country changing so that what had become plenty of money over and above what was paid by the university to people who had good incomes, the situation at some schools was that they still had leading salaries in the country from the medical school. Bob Howard never thought that sort of thing was appropriate. He thought if they had a big income total and most of it was from private practice, then why not give it to the departments that needed it more? But, I didn't think that was the way to go. The faculties of medical schools, at that time, I saw as being kind of one big organization. When people got increased salaries in some special part of the medical school, including basic sciences, the first two years of medical school, it did increase salaries and they were...like part of getting tenure.

When I went to UCLA part of what I did was to set up a place for the people who were in private practice to be involved in the over all University of California salary... The salaries were set at the top level of the University of California according to what titles the individuals had. If we did that, then it was a matter of the work that the people who were part time were doing as to what they would get from the university. That worked well. In the roughly two years that I spent there, I was able to recruit a dozen top people from around the country, because the department was still without any subspecialty. I went there with the idea that was my job, to get them going in that direction, and I needed the money for it. So I told the dean when he was recruiting me that I couldn't do that without adequate salaries for these people who were working part time. And it worked out.

DT: This was when you returned to UCLA in 1964?

RU: Yes.

DT: You were head of the Pediatric Department then?

RU: Yes.

DT: It's interesting. I saw a letter that I think it was John Anderson had written to Bob Howard or someone in the administration who was concerned that Pediatrics had lost a couple of faculty members in recent years, you being one of them, that you had gone

elsewhere, and Doctor Anderson reflected that you had gone to UCLA in part because the California system had a more flexible salary structure. Does that ring a bell for you?

RU: Yes, sure. [pause] I had a very short stay there. I was just there two years. Then, Bob Howard gave me an offer I couldn't refuse, but I had to be an associate dean in the process.

DT: [laughter]

RU: But I could be half a pediatrician. So that's the way that was set up. Although, he could not meet the salary I was getting as head of pediatrics out there, it was enough.

That's when I bought this house, when I moved back here at that time...just had the forty-third anniversary of this house.

DT: Oh.

RU: I live alone here. My wife died in 1981.

DT: Ohhh.

RU: She had a brain tumor.

DT: That's sad.

RU: I have three daughters [Jane Brissett, a journalist, Susan Nierengarten, a lawyer, and Cynthia Bulwicz, an RN and MBA]. When she developed her illness, all the girls had finished college and were doing well, and two of the three were married, and there were two grandchildren already at that time. So the loss didn't take away any of their bringing up by their mother, because she was around for all of that.

DT: You had said that Doctor Howard made a very attractive offer to you. Why did you want to come back to Minnesota rather than stay in California? What made being at Minnesota more attractive?

RU: Well, there was something on both ends, because the people that were in Berkeley, the headquarters for the whole University of California, changed in that time. When I got, I think it was maybe ten people recruited and good provision for their salaries, the people in Berkeley changed a lot of things. The dean of the medical school and the chancellor of UCLA didn't have much power. It all came from the new group of people that took over up there. So there was pretty clear evidence that I couldn't go on in the track that had attracted me.

Minnesota, right after I left, the school decided that they were going to double the number of medical students. Particularly in the clinical years, there just weren't enough places or people to teach that many more students. So Bob Howard got the funding that

was adequate to go that direction, funding from the legislature, to do that, because the legislature was behind the idea that we needed more doctors and the University should be the place to train them.

In the time that I had been a member of the faculty, I'd done a lot of teaching out in the hospitals by giving talks and so forth. So I knew a lot of these people both in pediatrics and surgery and other specialties by going out and getting acquainted with them. Both Bob Howard and I thought I had a good background for dealing with private hospitals and establishing teachers so that two or three a couple times a week could go to Joe Doe at Swedish Hospital and so forth. It did work out that way, and I was able to substitute for some of the money we couldn't pay them by offering them positions on a new kind of faculty. They were previously recognized...what was the word they used? Anyway, the word turned out to say to most of the people in practice who were given that that they're second-rate practitioners. But we got a new title for those people. The people who were the hospital officers and their committees is where I had to really get the privilege for them.

[break in the interview]

RU: Where did I leave off?

DT: You were talking about the relations with the affiliate hospitals and getting a new name for the faculty from those affiliate hospitals, those in private practice.

RU: I met a lot of nice people that were out there. We seemed to get along fine. By the time there was a change over, when Bob Howard left as dean, the problem had really been solved. So I just thought if there were enough funds, I would go back to full time in the Department of Pediatrics. Well, that worked out fine. Bob Howard rewarded me by making the extra part of the salary permanent in my salary structure.

[break in the interview – extraneous conversation]

DT: We were talking about your return to the University and taking on the role of associate dean, and that your responsibilities were expanding the teaching into these affiliate hospitals. How did the affiliate hospitals feel about the new responsibility in teaching?

RU: Of course, they had the option. More and more, as I went to these places, particularly to the big ones, Fairview and what now is Abbott Northwestern, those people, including their advisory committees, thought being part of the University was an honor. The doctors who were there, for the most part, were not very experienced in teaching, but we offered them ways to get more experience and so forth. I think at the end of the time where we had enough to take care of double the students, there was a good feeling that this was an honor, that it was not one that was going to make them more rich, but people would have more respect for those particular hospitals. They still do.

The person at Fairview Hospital was Platou.

DT: Carl Platou?

RU: Carl. I knew him a little bit. He'd been quite friendly with the Pediatrics Department and John Anderson before I had gone away. For the first year, I would go over to Carl's office one day a week. Carl and I would sit in his office eating his food and discussing these things.

The one thing that I'll never forget is that he said, "You know, it's going to be hard for some of your doctors to get over here. Parking is bad, and all that sort of thing. Did you ever think about our building a foot bridge from your hospital to my hospital?" I said, "No, that would probably cost a mint." He said, "Well, let's just give that some serious thought."

[chuckles]

RU: I could never get serious about it. He finally decided that there were other ways, and we weren't talking about having our full time faculty come to his hospital.

I enjoyed the time that I spent in that unusual part of the Medical School. But, I was, also, happy to have the opportunity to get back into Pediatrics.

DT: During that time that you were associate dean, in addition to doubling enrollments, there were also a lot of other things going on, it seems. The Medical School was revising the curriculum around this time, as well. Were you involved with that at all?

RU: Not very much. The group that I guess called themselves the Curriculum Committee of the Medical School had been set up pretty close to the time I left. So, when I came back, they already were operating a new curriculum that wasn't really a full new curriculum. That was easier to fit in because it allowed for more guaranteed time for the students to be in the clinic and to be seeing patients; whereas, otherwise, particularly when they were out in the other hospitals, we couldn't be positive about how much time they were taking.

They, incidentally, started a thing, which I think is still going on, of going out into the state and so forth. I did join into that as somebody who went to, mainly, places up in Northern Minnesota. The doctor who was there was taking on these people for, oh, one semester or one quarter, something like that. It was a change that I think was for the better and has still shown its worth by the way medical students now are handled in terms of teaching the clinical part of medicine. It got for a while that the teaching of the clinical part was done by the interns and residents who at that time were free.

[chuckles]

DT: With the increased attention on clinical teaching there was, obviously, less time for the basic science side. Do you recall if there was any trouble among the basic science faculty about that?

RU: Yes, there were people who were against it, you know, with good reason. At that time, the more basic science you knew, the better an academic doctor you would be. But, I didn't judge it, anyway, as ever being a serious rift in the Medical School, like this salary thing was.

DT: When I interviewed Bob Howard and [H.] Mead Cavert and Dick Magraw and others, they all indicated that, even though Doctor Howard eventually left the faculty issue alone, like the faculty practice issue, still, the fact that he tried to change the private practice thing, basically, tainted the rest of his time at the school.

RU: It seems that way, yes. He went from that to succeeding Cecil Watson over at Northwestern Hospital, and it was the most meager thing, you know. It was a make-do job just because he had a faculty position.

DT: Did you get any sense from the students how they felt about the revised curriculum? I know that they probably didn't appreciate the before and the after. But did students seem to appreciate the extra clinical time?

RU: I think most of them were happy with it. I don't know that the students were causing any problem, but I wasn't necessarily where I was a target by who was having problems, particularly in the University complex. My duty was, mainly, with the outside hospitals through that time.

DT: Going back to talking about those other hospitals... You had mentioned that among the University faculty, there was a tendency, at least earlier on in that relationship, to see those physicians as second-class practitioners. Did you get any sense that that was a fair assessment, I guess, when you were working with them?

RU: No, I don't think it was fair.

[chuckles]

RU: Because just being at the University didn't mean they were perfect. I don't think it ended with their starting to give their time freely to the University. There is even some of it around now, but so much less than there used to be.

DT: In the 1960s, but increasingly in the late 1960s when you were associate dean, there was a move afoot to try and create a second medical school in the Twin Cities. There was a group in Saint Paul trying to orchestrate that.

RU: Yes. That went on for quite a long time. I, again, wasn't really involved directly in any of the negotiations. It seemed like the people who were pushing for it didn't have a

grasp on what it took to start a medical school. Having been at UCLA as it was in its infancy, I saw that there were a whole lot of things that they couldn't do the way they were talking about it, and, actually, they ended up proposing to have that part of the school in Fargo, North Dakota.

DT: Oh, I didn't know that.

RU: The funding just wouldn't be available, as far as I knew.

DT: It seems, though, that where private practitioners in the community were affected, it created some change at the University in the establishment of Department of Family Practice.

RU: That's right

DT: That came about through the work of the Academy of General Practice.

RU: Yes.

DT: Do you recall any details about that?

RU: Yes. There was a fair amount of why would we want family practice going on? They chose—I think Bob Howard mainly—a man who was from up on the Iron Range. I'm blocking on his name now.

DT: Was it [Edward] Ciriacy?

RU: Yes. He was a guy who knew how to get things done. He was able to get some pretty good help from people were then known as the general practitioners. Of course, things continued on and have developed now so that people who are getting training in internal medicine post medical school are, also, taking on some training in pediatrics or some training in geriatrics and so forth. So it served as the seed of having pretty much a department setup that was equivalent to the other departments in the school, as far as quality of the people that were learning there.

DT: I think when it was initially set up that they had Ben Fuller, who was an internist, running the department.

RU: Yes, and he did not do a good job, generally speaking. The people who opposed having family practice could pick him out as somebody that wasn't what we would want. He was trained as an internist. I guess he just wasn't in a position to get much advice on the running of a teaching service. So he set it up, but it got much, much better quickly when Ciriacy came.

DT: It seems like it was through efforts of the Academy of General Practice and Herb Huffington, former president and who was then a regent... He was very effective at, basically, pushing Fuller out and bringing Ciriacy in.

RU: Yes, I think that's right.

DT: I'd be interested in your thoughts on this... When I interviewed Bob Howard, he indicated that he felt as though Herb Huffington's agenda was to get rid of him, Bob Howard, from the deanship. Do you have any...?

RU: I think that probably is true. I knew Huffington the same way I knew Bob Howard, before being a member of the faculty, because he was a member of the same medical fraternity. He was, at that time, criticizing the Medical School because they just went their way and they didn't pay any attention to the doctors out in practice and so forth. He just kept going that way once he got his own practice going. I don't know how much satisfaction he had when Ciriacy came and did a good job, but he should have had. I know it did take quite a bit of his time when he could have been home earning money and serving his small town.

DT: Huffington wasn't alone in having some mixed feelings about the Medical School. Why do you think there were such tensions between physicians in private practice and physicians in the Medical School?

RU: [pause] First of all, it wasn't something that was peculiar to Minnesota. It was going on all over. Back in the early part of the twentieth century, medical education was really changed markedly, and that's when full time faculty members came. As that happened and [there was] less dependency on part time or private practice doctors coming in for a little while and teaching, it sort of pushed them to go out. Having a university title was something that, although it was not money itself, it was like money for the doctor in practice because he would be more likely to be elected the president of his local AMA [American Medical Association] or there were a lot of state organizations like that, and they were *clearly* run by people in general practice. Status is what I'm talking about. As the head of the Minnesota Medical... What do they call it? [Minnesota Medical Association] Anyway, they did have good people and they had a publication. It wasn't as though they were second-class people, but they were different. That just remained. There's still some of it going on.

DT: One of the things that I've seen complained about in the archival documents among the private practitioners was that at the University there was too much focus on training specialists rather than these primary care physicians.

RU: Yes, that has kind of succeeded the way it was set up before where it was the status of all doctors that were under... The problem was divided in two that way. I don't think it made much difference.

I had mentioned that I had a lot of time that I spent with the American Board of Pediatrics. I was an examiner for them and had a lot of responsibility in designing the examinations for board certification and so forth. I was appointed from the American Board of Pediatrics to be their representative to the American Board of Emergency Medicine. It's the emergency room physicians. So I went and wrote some exam parts regarding pediatrics and so forth. For five years, I was on that committee. Internal medicine and obstetrics and pediatrics were the ones who had representatives. The other ones were people who were working in emergency rooms, and they were usually the officers of the Board of Emergency Medicine, but rubbing against those guys that were setting up this board for emergency medicine. They were very respectable and outstanding physicians themselves. They knew what an emergency department in a hospital meant to the finances and so forth. I think now that's pretty well settled.

The board had a lawsuit against it, including me, by people who had worked in emergency rooms. They said they should grandfather clause them in. Well, they did for four or five years. These people just didn't believe that they would cut it off to somebody who didn't do it within that period of time. But, finally—I think it's after about twenty years—the legal suit was settled that those people had no suitable qualifications to even bring that lawsuit representing other people—so, we're off the hook.

[laughter]

DT: Twenty years later.

RU: Yes, it went from one court to another. They weren't going to be denied.

DT: It seems there were a lot of sources of contest maybe or concern in the 1960s. Another thing that particularly relates to Pediatrics is there was a big effort to create a Minneapolis children's hospital in the 1960s. What can you tell me about that effort and the attitude of the Department of Pediatrics, perhaps, to that effort to build a children's hospital?

RU: Well, that was just, I guess, Pediatrics' substitute for some of the other things that were problems. People who were full time in the Medical School had a different idea than those who were in practice. I was on two different committees representing the Medical School that went back to, well, my first time on the faculty. The early 1950s was when I first was a member of that committee.

They had found a place which, at that time, was a maternity hospital, which isn't too far from here. It's on Penn [Avenue South] and Glenwood Avenue. Glenwood Avenue is right here and Penn is maybe a couple miles from here. The hospital required a lot of conversion if it was going to be a children's hospital. Then the people who owned that hospital finally got sick of the uncertainty, and they turned it into a place for older people who needed extra care. It's still that way.

Then the thing turned into situation where John Anderson had asked to have a meeting with all of his faculty and whoever wanted to represent the group in practice. We all pretty much knew all of them. We met in what was called the McQuarrie Library. It was filled up. It had a table sitting up in the front. John Anderson was sitting there, and the guy who was the head pediatrician at what was then the Saint Louis Park Clinic.

DT: Arne [Arnold] Anderson?

RU: [Yes.] Arne Anderson was there for the practitioners, but there were quite a few practitioners sitting around in the audience, as well. Arne got so mal-tempered. He was just saying things that you'd never think a physician would say to other physicians. Essentially, he imitated the guy who was, at that time, the dictator of Russia, the Soviet Union [Nikita Khrushchev].

DT: Hmmm.

RU: He took his shoe off and pounded the table. I've forgotten what the words were, but the words went right along..."We'll put them to death," or something like that.

[chuckles]

RU: A terrible threat to people if they didn't do things his way.

That thing really is presently in the form of the new Children's Hospital.

DT: Yes.

RU: You could draw a map and you would see that that came out of that. Dr. John Schreber who was before the present head of the Pediatric Department came with part of his vow to everybody that we'll get that new children's hospital as a consolidation of three hospitals: Saint Paul Children's, Minneapolis Children's, and the University. Well, they didn't get it, and, then, that's when it shifted over to building this one over by Fairview, which is going to be a wonderful facility. [University of Minnesota Amplatz Children's Hospital, 2400 Riverside Avenue, Minneapolis]. I hope it works well.

I'd say what started by 1950, as far as the people disagreeing about these things, having the good children's medicine in mind, each of them, it was just a different way of the process to deal with it at the level of very good medicine—and that's still going on. Since I haven't been at the University now for roughly twenty years, I don't know what the tone of it is, but I did keep hearing when this other guy was here—I don't remember what his name was—what was going on. There was one point where they said, "Well, we're going to have it now." Then, the next thing I hear is that the University is planning for its own children's hospital.

Actually, we had a children's hospital recognition long ago. It was just that there wasn't a separate building for the children's hospital.

DT: That's what I was curious about. So in the early 1950s, when you were first on this committee, did the Medical School feel that there was a need for a specific children's hospital or was the Medical School more interested in just ensuring that children were catered for within the existing hospital structure?

RU: Well, I think the concern at the Medical School was that with the children's hospital, the practicing pediatricians would be taking away, that they would be the consultants of the area instead of their coming to the University. You know, that would not only cut back the private practice earnings of the full time faculty, which wasn't very much at the time, but it would also limit the amount and type of clinical teaching they could do.

DT: It really has struck me that what's so crucial to being able to do a good job teaching students is to have the patients upon which to do the teaching.

RU: Absolutely.

What is likely to happen with what probably will be a big change when the Federal Government switches their voting... I'm worried that it's going to be a tough job for full time faculty members to live in what I visualize will at least be the environment that is going to start when the changes come. They're talking about you don't pay doctors for the number of procedures they do, but for the results of the procedures. Well, the University people have been in a position to get procedures as consultants that the other doctors haven't, because it takes multimillion dollar machinery to do these things. To have the wherewithal to do it in universities will, I think, be a likely victim of the political need to handle the finances of the doctors. But time will tell.

DT: Eventually, Arne Anderson was successful with he and his colleagues getting, obviously, the Minneapolis Children's Hospital established. It took them I guess if the discussions were begun in the 1950s more than twenty years to get the thing built.

RU: Mmm, I guess.

The Children's Hospital of Saint Paul existed then. There was one doctor. There were very few pediatricians in the area. There was one that owned that hospital. It was a private hospital. It was quite a ways from where the Saint Paul Children's Hospital is now, which is really kind of downtown. This was off on a high river bank. Then, they moved it to be close to the other hospitals and more accessible and so forth. So that went way back to the 1920s.

But it was the Minneapolis Children's Hospital and Minneapolis pediatricians who were really so oppressive about getting their own. Now, I've lost track as to how old that hospital is, but it must be twenty-five or thirty years old. You know, there was a little adjustment when that first came along that didn't last very long because it immediately became one of the teaching hospitals and not only medical students, but our interns and

residents were rotated over there, so we had to have some full time faculty over there. They were hybrids right from the beginning. I don't think anybody really took advantage of the other, purposely or accidentally.

DT: You've kind of highlighted the fact there that the Minneapolis practitioners had different interests than the Saint Paul practitioners. This is a sense that I've gotten that even though it's the Twin Cities, there are a lot of differences and, sometimes maybe, tensions between Minneapolis practitioners and Saint Paul practitioners. Do you have a sense of why there was that difference?

RU: No, I really don't. There is one factor that I suppose could play a role, and that is religion.

DT: Hmmm.

RU: The Catholics are pretty much in charge of a lot of things in Saint Paul, and they aren't in Minneapolis. I don't recognize any other religion that is that way in Minneapolis. I don't know that that really is a difference. You don't have to go back in history very far of this area... There was a real divide between the people who went to the Catholic churches and particularly the people who went the Lutherans churches. The Lutherans were quite adamant that the Catholics were not doing the right thing for their people—and they still are to a certain degree—but those things have pretty well settled themselves in some ways, anyway.

DT: That's interesting that you bring up religion, because a couple of other physicians who I've spoken with—I think Arne Anderson was one of them—drew attention to the fact that he and a couple of other physicians were Quakers, and it was being Quaker that had something to do with their approach to life. I can't remember if it was Doctor Anderson or someone else, but Quakerism came up.

RU: I don't know who is a Quaker.

[chuckles]

RU: Then, again, there have been so many who've gone through the program and been boarded [board certified] and now are practicing in town that I just don't even pretend that I could name all the pediatricians, which, for a long time, I could.

DT: It is something to see the way that religion could intersect here with the medical politics. That's interesting.

I saw some information that in addition to being associate dean with respect to the affiliated hospitals, you were also associate dean with respect to federal regional medical centers. Is that familiar? Was it the NIH or the Public Health Service in the mid 1960s that set up a program to build federal medical centers in different regions?

RU: [pause] Hmm... It doesn't sound familiar.

DT: It was called the Federal Regional Medical Center Program. It was about setting up regional medical complexes. I remember some discussion in the 1960s in essence trying to ensure provisional health services throughout the state and not having everything focused in the Twin Cities, but that there were core health centers throughout the state for people to get to.

RU: Well, now, I've heard that about the Veterans Administration needing medical facilities out around the state instead of all of them having to come right to the Minneapolis. But, no, I'm not familiar with that.

DT: Okay. Have you heard of the book *Masters of Medicine* [: *an Historical Sketch of the College of Medical Sciences, University of Minnesota, 1888-1966*] by Jay Arthur Myers?

RU: Yes.

DT: There was a little blurb in there on you. You're included in his assessment, not just in the Department of Peds but also in the dean's office description. I think it may have been there that I had seen that or it could have been something in the archives. But it must have been in there.

RU: Well, I guess I own that book, but I couldn't tell you what it said.

[laughter]

DT: I've looked at so many different things that I may have misspoken about where I got that information, but I saw it somewhere.

We talked somewhat earlier about the expanding enrollments for medical students and a lot of the changes that were taking place within the Medical School. But something else that was happening from the mid to late 1960s onwards was the broader effort to reorganize all of the health sciences and to abolish the College of Medical Sciences and establish, basically, the Academic Health Center.

RU: Yes.

DT: I was hoping we could spend a little time talking about that. Perhaps, if you could, tell me what your recollections are of the attitudes among the faculty about this effort to reorganize.

RU: [chuckles] I think I'm prejudiced by my feeling that the man who has been the leader of the whole thing is not a person that I respected very much.

DT: Who was that? Lyle French?

RU: No. The guy who is still with them, what is his name?

[door bell rings – break in the interview]

RU: Where are we now?

DT: We were talking about the reorganization of the health sciences, and you just started to say that you were prejudiced because...

RU: Yes. One of the things that's bothering me as I get older is remembering names. I find out that's kind of a viral problem of people my age.

Anyway, he's a big, heavy set guy. I think he was demoted from being the over all head of the medical sciences, just fairly recently.

DT: Oh, you mean Doctor Frank Cerra?

RU: Frank Cerra, yes.

DT: He's still vice president for the Health Sciences but, then, he's also Medical School dean as well, where previously he wasn't dean.

RU: Okay. I didn't know that he was dean now.

Without getting into any details, he and I got off to a bad start when he arrived here. His work, at that time—I can't talk about a lot of it—was not my idea of good science, and, yet, he was able to pass it off as good science. As he became vice president after Lyle French, there was just a difference of day and night of the way he handled people and things. Lyle was much more effective without creating a big to-do about it, for the most part.

DT: How about, then, when the change first happened and the fact that Bob Howard wasn't appointed the vice president, actually stepped out of the running for it? How did you feel and how do you think other faculty felt about Lyle French becoming the first vice president and Bob Howard leaving?

RU: Well, I think I would say that according to where people stood on that salary thing, they either welcomed Lyle or they said, "Why couldn't we get a good guy?" I always thought Lyle was a person that got things done. He was a neurosurgeon that was broadly honored around the whole country by what he did, just kind of the opposite on both research and clinical things with the guy who took over. So, that came and went. I don't think Lyle's leaving was something very many people wanted to happen. He was pretty much a friend of most of the people who count. I just thought that what kind of problems were occurring at that upper level were because the guy who was there didn't quite know how to approach things.

DT: What did you make of the rationale for even reorganizing things in the health sciences? Did you think it made sense to abolish the College of Medical Sciences? What do you think the impetus was for that?

RU: To me, it said you've got to not just be a clinical doctor if you're going to be at the University; you have to be a researcher. You have to learn basic medicine. It should be easier to do that if you have a situation where you can easily communicate with people in the other parts of the science world. I *always* worked with somebody in the basic sciences. The studies that I did just about until I retired had so much basic biochemistry in them. I couldn't do it myself; I had to have their help. So there were several people in the Department of Biochemistry that I worked with and Engineering was another school where I had several people I would go to. So I thought making it more homogeneous was a really good move.

DT: Do you think it actually had the effect of increasing communication between, say, the Medical School and the Nursing School and Public Health, for example? That was, obviously, the goal, but do you think it succeeded?

RU: I really don't know. When they changed deans... Now, I'm blocking on her name.

DT: Oh, Edna Fritz?

RU: No. Edna was in Nursing.

DT: The dean of the Medical School?

RU: Yes.

DT: Recently?

RU: Yes.

DT: Deborah [E.] Powell.

RU: Deborah Powell, yes. When she came, I sort of lost my identity in the dean's office. I had barely met her, and, all of a sudden, she's not dean anymore. So I couldn't evaluate what had been going on then.

I have spent more time by a considerable amount working for and with the people in the College of Liberal Arts [CLA] since I retired. I had the feeling that my education, because of World War II, was so skimpy in the College of Liberal Arts I wanted more. So, when OLLI [Osher Lifelong Learning Institute] came along—actually, the first name was Elder Learning Institute, ELI—I was a member from the beginning, but I got more and more acquainted with the people in CLA, and I still spend time with some of their sub subjects. The people in the Language Department now that have German,

Scandinavian and so forth are all good friends of mine. Until just a couple years ago, I was a mentor for any pre med students who were enrolled in CLA. But, now, they mainly come in through the department which is headquartered in Saint Paul. What is that? The word bioscience wants to come out, but that isn't the name of it.

DT: The College of Biological Sciences?

RU: Yes, that's it—and you've only been here a year!

[laughter]

DT: That's what you get for studying the history.

RU: Now, I think that's good that they go over there, but I think it's too bad that they don't have more time to go to CLA. They've got some wonderful faculty there. They're so teaching minded compared to the people in the Medical School. CLA loves to teach.

DT: [chuckles]

You had mentioned, given your own research interest, that you had a lot of good relationships with the basic science departments, especially Biochemistry. Do you feel that was an experience that was shared among other medical faculty?

RU: A lot of them.

DT: Do you feel like there were good relationships between the clinical sciences and the basic sciences?

RU: No, but I don't think I hurt it any. I thought that it was good for them, and so did the people that I worked with. The head of Biochemistry for a long time was somebody who urged me on to doing that.

DT: What was his name?

RU: Wallace Armstrong.

[pause]

DT: I know there had been some discussion, I think it was in the 1970s, some debate about who would teach the basic sciences to the medical students. Would it be the basic scientists within the Medical School or would it be those within the College of Biological Sciences. Do you remember much of that?

RU: No, I don't. I was aware that that was brought up. I didn't think at that time the other college was prepared to do that sort of thing. I think maybe they are now.

DT: How did you think the relationships were between the Medical School and Nursing and Dentistry and Public Health before the reorganization? Did you have a lot of interaction with the Nursing School, for example?

RU: Not a lot, but some. I'm trying to remember the name of the woman that had been head of the Nursing School for a long time.

DT: K.J. [Katherine] Densford?

RU: Yes. When she retired, the Nursing School started expanding, and I thought they were biting off more than they could chew, but it worked all right. You know, they remain a force in the national nursing education.

We've been talking about the disagreements at the functional level of so many different things now. I never sat and talked about them at one time. I realize how much of that there really was.

The nurses working with patients, with doctors in Pediatrics I think had a lot of advantage because their patients were young kids and both the doctor and the nurse were determined that this child was going to get the very best that we can do. Whereas, on the other services, when I've been a patient and seen the way the nurses and the doctors *don't* get along, I thought Pediatrics did pretty well.

DT: I don't know if you will have been involved with any of this... I brought up Edna Fritz's name, in part, because she's on my mind. As I understand it, she faced a challenge when she was dean in that a lot of nursing faculty objected to her leadership style, and they, actually, left the University, and, eventually, Bob Howard had to let Edna Fritz go. Were you aware of any of that that was going on?

RU: Well, when the new person came [Isabel Harris], I fairly quickly learned that it had been going on, but I didn't really know that there was a big to-do. Edna Fritz was a likeable person, and that's about all I can say, because I didn't really know much about her programs or anything.

DT: Another group that I'm curious about... Did you have much interaction with the Mayo Clinic and the Mayo School of Medicine when it opened?

RU: Yes. Early on, back in the 1950s and 1960s, in our department, we dealt with their department that required that they get a master's degree. So, we had to form the committees even though we didn't have a master's degree to be the examining committee for getting the degree, which is what got me interested in the people who were down there. Then, I became good friends with Dr. Alvin Hayles who established endocrinology and pediatrics down there. He died about ten years ago, after I retired. So, I had that.

Then, when I got back from UCLA, when I was in the dean's office, I was on the committee with the man who headed their business in... He was a neurologist, and he was a very intelligent and respected doctor in the Mayo Clinic. I'm trying to think of the name of the... The Federal Government ordered a situation that we both were trying to guide how to do it here.

DT: Oh! yes. That's actually the program that I was... The regional...it was Heart, Stroke and something else. [Heart Disease, Cancer and Stroke Amendments, Public Law 89-239]. That was the title of the act, but it was, then, really the Regional Medical Program.

RU: Yes.

DT: Yes, this is the thing that I was asking about.

RU: We had a lot of committee meetings, and there was always agreement between the Mayo Clinic and us to do it certain ways. Yet, not long after that, they began having their own students and they dropped the requirement that their house staff get master's degrees. So, in a way, they just broke away from the University that way. But with my friendliness with a couple of people down there, they would come up and give a talk at one of our grand rounds or something like that. The same...we would go down and do that sort of thing.

I went twice as a patient to the Mayo Clinic to get a consultation. I've had cancer many, many, many times now. But, at that time, I had my first one, which was cancer of the bladder, where I had to have my whole bladder removed. So, before I allowed that to proceed, I went and saw the people in Urology at the Mayo Clinic. They agreed that was the only thing that would work—and it worked. Then, let's see, it must have been about fifteen years later, I had cancer of the lung. Again, I went to them, but I had the surgery done at Minnesota [University Hospital]. Now, I just get skin cancer.

DT: That's incredible that you recovered from so many bouts with cancer.

RU: Well, you know, I look at it in a different way, that I'm vulnerable to getting it and I'm pretty good at getting rid of it. I credit that with the fact that I've had very good physicians to go to myself. I have had *almost* all my care at the University Hospital.

DT: With regards to those committees that you were on with the Mayo people about this government program, did anything ever come of it?

RU: No [whispered]. Not really. They went their way, and we went our way, but we were collaborative and we used the government's money...

DT: [laughter]

RU: ...which was why we were in it. A lot of the money went to building up the parts of the school that did heart, cancer, and stroke.

DT: When I give you the transcript, I'll have inserted the correct name in. [laughter]

RU: Then, I'll know.

That went on most of the time I was in the dean's office, as a matter of fact, but it was not my primary assignment.

DT: When did you retire from the dean's office? When did you leave the dean's office?

RU: When Bob Howard retired in 1970.

DT: Then, you just returned to the Department of Pediatrics?

RU: Yes.

DT: When did you retire from there?

RU: In June 1990.

DT: I'm focusing right now on the 1950s, 1960s, and 1970s, but, at some point, I will delve into stuff from the 1980s and 1990s. So I may want to come back and talk to you again once I know the questions to ask about the 1980s and 1990s. [chuckles]

RU: Well, I can't go any farther than that because I really retired from all things medical in 1990.

[laughter]

DT: I don't really have too many specific questions left, other than if you have some comments about some of the changes in the medical culture and medical practice have been, that you've seen during your career.

RU: They're so huge that it's a little hard to talk just about the changes. When I got in the Medical School, the things which I learned probably lasted for ten or fifteen years as useful information. Because of funding of research and research being done on things I'm interested in—I'm not talking about my own; I'm talking about the general things in parts of the world that do good medical research—as awful lot of things changed and most of them for the better. There are some things that the change has made it more difficult to deal with, but, for the most part, if it's difficult, it's because you need a bigger machine. So, then, you need more money to buy the bigger machine and somebody to run it and so forth. That's the way, I think, we are operating medicine now. That's the way I see it from the outside. This OLLI has been good for me because I've got several

inputs of what's going on in medicine through that. Otherwise, all I would know is what my dermatologists tell me when I go to get a skin cancer taken care of.

[chuckles]

DT: Tell me again what the OLLI stands for.

RU: Osher—that's the name of the man [Bernard Osher] who was the philanthropist.—O-s-h-e-r, Lifelong Learning Institute.

DT: That's on the campus?

RU: Yes. Their office for headquarters is on the second floor of McNamara [Alumni Center].

DT: Oh, interesting. I've learned more than one thing new today.

RU: They also own a fifty-seat classroom right next to the office.

DT: Oh, wow.

RU: We have a lot of our classes there, but our classes are spread all over the Twin City area.

DT: Do you have anything else you'd like to share with me about your experiences at the Medical School?

RU: Well... I've been lucky that the medical schools that I've been associated with have always been not just accepting of basic research but leaders of basic research. It's a real satisfaction to me that, now twenty years after I retired, most of the things that I learn about new things, I can at least learn them because of my background on both the basic and clinical level.

Although, I know nothing about politics—I deny that I'm either a Democrat or a Republican—I just fear that the people who are in charge of changing over... [President Barack] Obama still brings up that people want change. I don't know what they're going to change to that would preserve the best of what's going on now and take care of some of these things, which I think are relatively minor, that are necessary, desirable, and so forth. So to have somebody who has the authority and the backup to make changes... I'm saying the insurance companies can't turn a person down because of an existing condition, and you have to get your insurance in the same state you live in, those need to be changed. There's no question about it. Everybody should have access, the ability to pay, and having medical insurance would be, still, a good way to do that. But all the stuff that isn't underlined is going to creep in there, and I hope will not have side effects that would ruin those parts as well as other parts. [pause] I just think we'll be lucky if those

kinds of changes are made and there isn't something about the good parts of medicine that get left behind. But, I can't tell you what that is.

DT: [laughter]

RU: Don't come to me. [laughter]

DT: Thank you so much. This has been very informative.

RU: Thank you for spending your time with me. I'll look forward to seeing what I said.

[laughter]

DT: Yes, indeed!

[End of the Interview]

Transcribed by Beverly Hermes

Hermes Transcribing & Research Service
12617 Fairgreen Avenue, St. Paul, Minnesota, 55124
952-953-0730 bhermes1@aol.com