

Robert B. Howard, MD, Ph.D.
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

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

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

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

Biographical Sketch

Robert Howard was born in St. Paul, MN, on December 25, 1920. He did his entire post-secondary education at the University of Minnesota, where he received his BA in 1942, his MD in 1945 and his Ph.D. in 1952. He served his internship and residency in the University Hospital. Howard was a Teaching Fellow (1945-46), an Instructor (1948-52), an Assistant Professor (1952-53), Associate Professor (1953-58) in the Department of Internal Medicine; a Professor (1958-82) and a Clinical Professor (1982) in the Department of Medicine; the Director of the Department of Continuation Medical Education (1952-57); Associate Dean of the Medical School (1957-58); and Dean of the College of Medical Sciences (1958-69). He also served as a captain in the Army Medical Corps in 1946-48, the Director of Medical Education at Abbot-Northwestern Hospital (1971-82), and Editor-in Chief of *Postgraduate Medicine Magazine* from 1982.

Interview Abstract

Howard begins by briefly discussing his childhood, his schooling, and his experience in the Army Medical Corps. He then reflects on teaching and working in the Department of Medicine at the University of Minnesota in the 1940s and 1950s, including the changes that he observed in medical care providing after World War II. He discusses his administrative roles at UMN, including director of the Department of Continuation Medical Education, associate dean of the Medical School, and then dean of the College of Medical Sciences. He discusses the faculty private practice controversy in the 1960s, including the option of a strict full-time system. He describes his role in the reorganization of the Pharmacology Department, the establishment of the Ophthalmology Department, and appointing John Najarian as head of surgery after Owen Wangenstein retired. He discusses the increase in the Medical School class size in the 1960s, the attempted establishment of a medical school in St. Paul, the establishment of a medical school in Duluth, and the establishment of the Academic Health Center. He discusses the Nursing and Pharmacy Schools and some of his department head appointments while he was dean. He describes what he did after leaving the UMN, including working as director of Medical Education at Northwestern Hospital in Minneapolis and as editor in chief of *Postgraduate Medicine Magazine*. He reflects on the state of the funding of medical education in Minnesota while he was dean, the influence of the introduction of Medicare and Medicaid, the influence of federal legislation on the Medical School in the 1950s and 1960s, the perceived shortage of healthcare workers in the 1960s, issues of space in the Medical School, the role of external committees and reports in Medical School decisions, the relationships between the Medical School and local physicians, the state legislature, the Regents, and the Mayo Clinic.

Interview with Robert B. Howard

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed on March 5, 2009

Robert Howard - RH
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I am interviewing Doctor Robert Howard. It's March 5, 2009. We are doing the interview at Doctor Howard's office which is at 1748 Oakmont Drive, Walnut Creek, California.

First off, obviously, thank you for agreeing to have me interview you.

What I'd like to begin with is, perhaps, if you could just give me a little bit of background about where you were born, how you got into medicine and how you ended up at the University of Minnesota.

RH: I was born in Saint Paul, Minnesota, on Christmas Day 1920. My father was a physician, Willard S. Howard. My mother was Edna Bole Howard. Bole, B-o-l-e. I was an only child; at least for most of my early life, I was an only child. I grew up in the Midway District of Saint Paul. I went to Central High School, went to the University of Minnesota. My father was a doctor, but I can't honestly say that he ever sat me down and said, "You must be a doctor." But I grew up with people surrounding me saying, "I suppose you're going to be a doctor like your daddy." I'd nod, "Yes." I never gave it much of any thought beyond that. I expected I'd be a doctor, and I was. My mother's father was also a doctor, so there were three generations there. I went to the university, the Arts College for three years. Three years of pre-med was required at that time. Then I went into Medical School in 1941.

I was studying anatomy on the evening of December 7, 1941, when the radio brought news of Pearl Harbor. We were almost immediately put into a circumstance where we were no longer subject to our local draft boards. The first thing that happened to us is we were made second lieutenant reservists in the Medical Administrative Corps to protect us from that. About the second or third year of Medical School, the ASTP [Army

Specialized Training Program] began and we were privates first class in the Medical Corps, but we were still in school. Clothes were provided for us, books were provided, tuition was paid. I was there in that protected situation all during the active war, so I never heard shots fired in anger. I got married during that time. In addition to the other amenities, I got \$160 a month, which was big bucks in those days. We had a house. My first child was born while I was still in Medical School.

I did well in school and was offered an internship at the University Hospital, which was something of a prize. I had contemplated a private hospital internship in Duluth [Minnesota] before that, but when the head of the Department of Medicine asked me to stay on at Minnesota as an intern, I was honored, and I did so. I had nine months of an internship. They were pared down because of the war. I had nine months of residency in internal medicine. So I had eighteen months experience and, then, I had to go on active duty. The war was over. I went to Keesler Field, now Keesler Air Force Base, part of the Army Air Corps in Biloxi, Mississippi. I was there for slightly less than two years. I returned to finish my residency at the University of Minnesota. Before I was actually finished, I was offered a post as instructor in medicine, but I was still continuing my studies leading to my qualifying for the American Board of Internal Medicine. I decided I liked the academic life, and I stayed there at the university for a number of years.

DT: Who was the head of Medicine who invited you to do your residency?

RH: C.J. Watson, Cecil James Watson, a *marvelous* man, one of the smartest, brightest and one of the handsomest men that you ever could imagine. If you'd sent over to central casting for somebody to fill a movie role as the doctor, you'd have gotten Cecil Watson.

DT: [chuckles] That's fantastic.

Could you describe a little bit of what it was like teaching and working in the Department of Medicine?

RH: Well, there were a couple of different phases of it because the war came to an end and that changed things quite a bit. When I was an intern and a resident, the first year of the residency, there were just two of us, Howard Horns and myself, as intern and resident. Excuse me. That's wrong. There were two of us who were residents. By that time, another group of interns had come in. So there were about six interns and two residents, and there were four members of the staff. That was Internal Medicine in 1944 and 1945. When I came back in 1948, everything had changed. There were many, many residents. The VA [Veterans Administration] had joined the program and there were residents out there. Staff had burgeoned to probably thirty people at that time. So things were quite different.

I enjoyed teaching. Unlike many physicians, I kind of enjoyed the hospital at night. It was always a place where you could sit down and get acquainted with somebody and really get to know what made him or her tick. In those days, you understand, hospitalizations were much longer than they are now. A patient with a coronary stayed

six weeks. Today, they're out in ten days or less. At night it was kind of interesting, kind of fun to go and sit at the bedside and learn about things in their lives and what they were all about. That was different after the war.

Other things were changing. I'll come to this, probably, in some other things you will ask me about subsequently. The nature of the patient population had begun to change. Prior to the war, most university hospital patients were what were called county patients. Are you familiar with that term?

DT: I am, but, perhaps, you could explain it.

RH: Most people in those days didn't have health care insurance. If they had a difficult illness, they were referred to the university. They didn't have the funds so the county and the state shared the expenses. An amount was appropriated by the state in each legislative period, which was two years, against which the hospital could charge. The county would pay half the patient's bill and the state paid the rest. So these patients were—one hesitates to use the word—charity patients, but they weren't the same as a private patient. In this period, there were beginning to be a few private patients. They were almost exclusively patients of the department head or the head of the service. They did come along and, subsequently, as we'll get to later, this became quite an issue.

By the time I returned in 1948, it was already beginning to change. The patients had a little more money. Blue Cross Blue Shield was sponsoring patients. Many people had that, so the whole pay set up, paying for health care, was more complicated, and health care costs were rising. I can still remember the day when the director of the hospital lamented that he had to put the daily rate up to ten dollars a day.

[chuckles]

DT: That would be nice if that's how much it cost nowadays.

RH: Yes, now you start at two more zeros after that.

I became an instructor in the Department of Medicine. That's the lowest rung of the academic ladder. It was customary in the Department of Medicine to work toward an advanced degree, a Masters of Medicine or a Ph.D. This was something that was almost entirely peculiar to the University of Minnesota. I don't know how much you want to know about this. I know a lot about it. [laughter]

DT: Interesting. One of my colleagues has just written a book on this, on graduate medical education [Jennifer Gunn, *Unfulfilled Prescriptions: Graduate Medical Schools in Twentieth-Century America*]

RH: Oh, is that right?

DT: But, for the record, perhaps you could tell us a little about it.

RH: The development of advanced degrees in medicine was, in a way, a sidetrack. It was thought that this would become the way in which specialty people were denominated, that if you wanted to go into internal medicine, you'd work towards a master's or, indeed, a Ph.D. degree in medicine and the same in surgery. The Mayo Foundation had come along about this same time and had the same idea and joined forces with the graduate school at the University of Minnesota.

So I worked toward a Ph.D. and did some studies in iron metabolism, but I got sidetracked from that for a time, because I moved into my first administrative role. My story will reveal that wherever I came to a fork in the road, not as Yogi Berra said I took it, I chose the administrative. [chuckles] In 1951, I was offered the job as head of the Department of Continuation Medical Education. I continued as an instructor in medicine—that was my title. But this was an administrative role. Minnesota had been something of a pioneer in presenting continuing education for practicing physicians. It was a very popular program instigated by a well-known doc named William A. O'Brien and carried on, subsequently, by George Aagaard, who was a good friend of mine. He left to become dean of the then developing school at Dallas, Southwestern University [Texas]. So I was invited to take that on. So when my administrative role began, I was an instructor and a department head, which was kind of an anomaly. I wanted to be advanced academically, but the rule was that you couldn't get your Ph.D. degree if you were already a professor, in professorial ranks. That was then your colleagues judging you as a peer.

DT: Sure.

RH: So I had to hustle, and I sat down and wrote my thesis, a copy of which is in there, by the way. It isn't very good, really.

DT: [chuckles]

RH: I hustled and got the Ph.D., which had been laid aside. I think I got that in 1952. In any event, I continued in that role for, essentially, five years.

There were a couple of side duties. One was I was the secretary treasurer of the Minnesota Medical Foundation, which, then, had in its command about \$40,000 for scholarships. I also presided over the medical staff meeting every Friday noon and assigned the various departments. They were quite a thing in their day; they were very good. It was a time when the staff was interested in what was going on in other departments. That gradually changed and an ophthalmologist would come only when there was an ophthalmologist was presenting and so on. They were good, and I did a good job with that.

Then another thing that occurred in 1954 was the completion of the Mayo Building. That had been a project that Doctor Harold Diehl, my predecessor was very interested in, with

the help of Doctor Donald Cowling, who had been the... Are these names familiar to you?

DT: Yes, they are.

RH: Cowling had been president of Carleton [College, Northfield, Minnesota] starting at his age of twenty-six.

DT: Wow.

RH: He felt very strongly when he retired as president of Carleton that he should get out of the way of his successor, and he *really* did so. He never set foot on the campus again. He became a very good friend of the University of Minnesota Medical School and taught me a lot about fundraising, notably how important it was to keep faith with donors. If they gave money for something, you saw to it that it was used for that purpose. At that time, he was an old man. In our last years together, he finally called me “Bob” and I called him “Don,” but that took a long time.

I was asked to chair the festivities for dedicating the Mayo Building. I guess I did a good job of that, because that brought me into prominence within the institution. People knew who Bob Howard was or Doctor Howard was.

My ambitions were growing. I guess I wanted to advance, and I recognized I never was going to advance in research. I didn’t have that kind of mind. I had no really good ideas of that nature, so I saw my advancement as administrative.

Doctor Diehl had become aware of me through this other business, and I believe he became fond of me. He decided in 1956 and, in 1957, he left two years before the mandatory retirement age to take a job as the senior vice president for research at the American Cancer Institute. He, at the time, saw something in me that that I guess I was pleased that he saw. [chuckles] In any event, I was appointed associate dean and the deal—that’s d-e-a-l, not D-i-e-h-l—...

[chuckles]

RH: ...was that he was going to remain on the faculty one-quarter time and return and hold my hand during this period of time. It didn’t quite work that way, because almost as soon as he got to New York, he went into a serious depression. I don’t believe he’d ever had this before. One could attribute it to leaving the place where he’d been the head honcho for twenty-three years and so on. But, in any event, he had a severe depression; and, although, he was back a couple of times, when he was back, he was very depressed. I sat with him one time when he couldn’t decide whether to go to lunch or not. It was really sad to see. He, later, came out of it. Although, I was never named acting dean, I was de facto.

The university was carrying on a search for the new dean, and I, obviously, hoped that I would be the one that they chose. They had a couple of people who were kind of stalking horses. The one that would have been appointed had he been available was George Aagaard. George Aagaard had left as head of Continuation Medical Education. He'd been a dean at Southwestern. He had, subsequently, gone to the University of Washington, where he did a *very* fine job as dean and then quit after ten years. More power to him [spoken very softly]. George, I'm sure could have had the job, but he said, "No," that he wasn't available. So along about April on almost the same day that my fifth child was born, the president, James L. Morrill, brought me in and said that they had voted to recommend my appointment as dean. Needless to say, I was pleased, and I was riding the top of the wave.

A little side note... Mr. Morrill had kind of an eye for the ladies and he always thought my wife was pretty. [chuckles] He said, "How many children do you have?" I said I had five. He said, "I suppose you're Catholic." I said, "No, we're just passionate Protestants."

[laughter]

RH: Anyway, that's how I got there, and I had a little longer honeymoon than [United States President] Barack Obama is having. I had about a year's honeymoon. Okay?

DT: That's great. I have a few follow up questions to ask about this period.

RH: Sure.

DT: First of all, can you spell George Aagaard's last name?

RH: Double a-g-double a-r-d.

DT: Excellent.

Tell me a little bit about the Department of Continuation Medical Education did and what your responsibilities were there.

RH: Well, physicians were just beginning to realize that medicine was moving very fast, that they couldn't say, "Gee, I went to the world's greatest medical school, and I know everything, and I don't have to study anymore." Various institutions were getting into the business of presenting postgraduate courses. Minnesota didn't initiate it, but it was one of the early entrées into the field. Actually, it had been a big supporter of post graduate education generally, continuation education. You may or may not know—I don't know exactly what's happened to it—there was a Center for Continuation Study on the campus up where the museum is. It had a novel approach. It was a place that was partly a small hotel, and people could come there and have rooms there. They had their meals there, and they'd go to courses and classes. This was in various fields.

A medical professor named William A. O'Brien, kind of a fat, jolly man, who taught public health, and was quite a character and well known in the community, said, "Let's offer courses for physicians." So he would put together a year's program in cardiology and another in ophthalmology and another in this and that, various subjects. He would find experts in the field and local people who were experts and put a program together. A program characteristically would have one well-known outside person whose name might be attractive and would have one or two from the Mayo Clinic, and the rest from the local faculty.

The job of the director was to twist the arms of these people to come and make their speeches and, then, preside over the meetings—they were usually two days or two and a half days—for mostly Minnesotans or adjacent Wisconsinites. We had a mailing list, and we'd send out flyers announcing the program. We got good responses to it. A program might attract fifty physicians, occasionally more and occasionally fewer. I had to cancel one or two. This was my job. I'd have to know who the top experts were in such and such a field and whose name might be attractive. To the extent that I could find out, I'd try to find somebody who presented things well, because some people wrote well but didn't speak well. That was kind of interesting, and I enjoyed that. Now, this whole thing has changed. It was changing right along then. More and more institutions were getting into it and pharmaceutical companies began to present their own names, so the field changed and didn't really stay like that very much. Anyway, I had a good time. These were the 1950s and life was good. It really was good. I was, of course, pleased to have been named director of the program.

DT: Did the physicians who came to the programs pay?

RH: Yes, they paid. I've forgotten some of the details of that. They didn't pay an awful lot. It was probably thirty-five bucks or something like that, but it paid for the program. It actually paid my salary. My salary really came from that; although, it went through the university. I was a university employee for which I was glad. Yes, it actually paid for my salary.

The program had been probably a decade old by the time I came into it, and it had already been changed. The Center for Continuation Study was outmoded. It didn't have really private rooms, and it was a time when people didn't want to move in with some doctor they didn't know, unless it was a pretty woman doctor, I suppose.

[chuckles]

RH: The meals there weren't as attractive as going out to Charlie's Restaurant [in Minneapolis]. So things changed, and it was less what it was originally conceived of as an all-in-one proposition. But they paid for that and we paid a modest honorarium to the speakers who would come from Michigan or Atlanta or wherever. I don't think there's anything like it anymore. The programs that are around are on a much different scale, and you can learn just about anything you need on the net [Internet] anyway. So you can do that as well.

DT: So in the 1950s, the pharmaceutical companies weren't funding the department in any way?

RH: Oh, I suppose there were a few... They weren't funding that department, no. No, they weren't. There were some pharmaceutical company grants to various departments. Pharmacology probably had some grants from them, but they weren't causing the kind of problem that they are causing today. They advertised only to the profession; they didn't advertize to the public: "Ask your doctor if such and such is good for you."

[chuckles]

DT: Just a little bit more about your experience as associate dean... I'm curious... How many other assistant deans were there while you were associate dean?

RH: [pause] I believe there were two at that time. Albert Sullivan was assistant dean for students, and I think both Mead Cavert and Neal Gault were also in the dean's office; although, Neal wasn't exactly at that time, because I put the finger on him to take over my role in Continuation Medical Education. So I think it would really be Sullivan, Cavert, and I in the dean's office, and Neal standing by in what I had formerly been doing.

DT: Now, if we move forward to when you are the dean... I guess maybe if you want to say something about your early years in that position and, particularly, if you would, speak about the faculty practice issue.

RH: Now we're getting to the tough part, aren't we?

DT: [chuckles]

RH: Well... I had a honeymoon of about a year. I don't think anybody was mad at me during that time. A couple of things I did were I had managed to redo the Pharmacology Department. It had really been in the doldrums and not much exciting was going on there. I managed to get some funds from someplace or other, and I enticed Doctor Fred [Frederick] Shideman to come from the University of Wisconsin as the head of the department, and he brought with him about three, if not more, people, and it became a really good department, and I think continues to have that image.

I got in a little trouble there, not with my faculty, but the president of the University of Wisconsin complained to Mr. Morrill that the dean had stolen all his people, which happened to be pretty true, I guess.

[chuckles]

RH: In a way, the University of Wisconsin president had himself to blame for that. He was at odds with his medical dean who was a friend of mine.

Anyway, that's one thing I did in that early time; we revamped that department to its benefit.

I had also been able to establish the eye department. In fact, when I became dean, it was still the Department of Eye, Ear, Nose, and Throat. Earling Hansen, who was the head, was part time—he had an office downtown, which is the way some of those departments were operated at that time—had retired, and I went searching for a new head. We had decided to separate it and make it the Department of Ophthalmology. I identified Doctor John Harris, who at that time, I believe, was in Iowa, who was not only an established ophthalmologist, but he had a Ph.D. in biochemistry, as well. So he seemed like somebody who would be able to put the department on a good track and bring in some research. That became pretty much a full-fledged department under John Harris. John, later, developed some personal foibles that didn't do him any good, but the department he established was a good one and went on, and I think has continued to thrive. I take a little credit for those two departments. Subsequently, I did comparable things in Otolaryngology, the other part of that.

Those were some of the accomplishments and some of the things I did in the first year, in the honeymoon time. I did some other things even when things were more difficult, but those are notable things that stand out in my early year. I enjoyed it. As I told my wife and other people, this was my macho bit. I was terrible at athletics. I was mediocre at tennis and poor at everything else. I was the last one chosen when the sides were drawn. Becoming dean at age thirty-seven—I was thirty-six when I became acting dean—that was my flexing my macho muscles.

DT: [laughter]

RH: It was fun.

To get to the hard part... President Morrill in appointing me said, "You know, you've got to deal with the growing business of private practice in the Medical School." To back up just a little bit and remind you of what had happened... The county patient was on the way out nearly totally by the time I became dean, or probably didn't exist anymore. Not only were the department heads seeing a few private patients, just about *everybody* was seeing private patients. The old idea that patients had to be referred not just by another doctor but by a doctor of your specialty had gone by the boards. We were all out there happy to have lines of reference. So it was becoming pretty much a private hospital. Morrill had seen this happen. Diehl dealt with it in his customary way. He had a good way of dealing with things: he didn't do anything about them.

[chuckles]

RH: It was always surprising to me how many things got resolved that way—but this one didn't.

What I saw was several things happening. One was that people were paying lots and lots of attention to their private patients and not necessarily to other things. Some of the big earners in the more surgically oriented specialties brought in big money. It often was ten to fifteen times as much as their academic salary. Believing that where your treasure is, there lies your interest, I thought that presented some difficulty since they weren't *really* devoting themselves to what I considered the old academic life: you didn't make as much money but you got a lot of pizzazz out of teaching and the honors that went with it. This was turning around. So that was one aspect.

Secondly, they did this with the University Hospital picking up all the expenses. They didn't have the expense of a downtown offices and things like that. They had that all right there. It was my contention that, somehow, the university and the Medical School ought to receive what a clinic would receive or a professional building would receive or whatever.

The third aspect was that as we zeroed in on having only private patients, the melding of the teaching function with the medical function was difficult. When they were county patients, I would not say that they were experimented on, but it was easier to say to a patient, "Well, you're here and we're happy to take care of you. One of the things, some of our young doctors will be examining you. We hope you'll participate." And they did. Private patients didn't necessarily feel that way, and, very often, their doctors felt even less so. "No, I don't want anybody touching my private patient." Well, I figured you couldn't have a teaching hospital full of patients who couldn't participate.

Morrill had told me to tackle this; so, I tackled it. That's when my honeymoon ended. Lots of factors were already against me. There were docs who saw this as a personal affront, or that, I, the dean, was wanting to take over their rights, and that they were being taxed unfairly and so on. There were some very capable opponents, in particular, Doctor Richard Varco of the Department of Surgery, and Doctor Donald Hastings of the Department of Psychiatry. They felt this was a move toward socialized medicine, which was a swear word. It's still almost a swear word; you can't talk about it even though, in my view, we badly need a single-payer health care system.

Well, anyway, one of the things that I thought we ought to do was to have central billing; in other words, become a health care institution instead of a bunch of little shops, and that suggestion got really zapped, because I was for central billing and kind of a centralized approach to health care.

I was influenced in this not just by what I said but by a couple of colleagues who had some really good ideas about what was happening in the health care field and what might be done, and what was going to happen in the rest of the century, namely, Doctor Richard Magraw, whose name you've maybe some across...

DT: Yes.

RH: ...and Doctor Ben [Benjamin] Fuller, whose name you've maybe come across. They had notions of what was happening and how specialty medicine was taking over, and we really needed to have some return to having a kind of family doctor who could manage the whole scene. I think they foresaw the real need for some kind of single-payer health care plan. I was influenced by them. My ideas were not especially popular.

We evolved a plan. Maybe your archives will tell you what all happened in this. Along about 1960, some kind of plan was developed. I've even forgotten its particulars. But the opponents managed to get it held up. I think the Regents had acted upon it at that time, but you can't quote me exactly on this because I've lost track of what happened. What I do know is that J.L. Morrill had lost his nerve about this. He was a member on the board at Westminster [Presbyterian] Church [Minneapolis] and Donald Dayton, the head of Daytons, was a member there and other people. He'd go on Sunday, and they'd say, "What the hell is that young dean doing making everybody all excited over there?" So he kind of backed away and set aside the thing that had been developed, saying that he was unsure that it had appropriate appellate functions and so on. So that kind of cancelled that. He left, and I didn't make any particular headway at that point.

O. Meredith Wilson became president, a very bright guy. You hear about him, I'm sure.

DT: Yes.

RH: A very, very bright guy and a Mormon. Mormons are known for their entrepreneurial spirit. He didn't ever really believe... He had no heart for what I was saying. He, I think, mainly admired the entrepreneurial spirit of these guys that were getting the six-figure incomes. So I can't say that he backed me very much.

In 1963, there was another thing adopted, and you've probably seen that, haven't you?

DT: Yes.

RH: I think I've got a copy of that among my stuff there. It was passed by the Regents, but objections to it were raised so quickly and the president and his then vice president for Academic Affairs, Malcolm Willey, quickly took all the teeth out of this. We had a meeting. I can still picture the meeting, in which we went over it bit by bit. Willey sat there and said, "We'll take that out." "We'll take that out." At that point, I knew I was licked. I said I'd never raise the question again, and I don't believe I did. *But*, I'd been tarred with a brush, and, from that point on, it was somewhat harder to accomplish anything, anything of importance. One group was likely to be opposed to it because it had come from me. So...

I don't say I didn't enjoy the rest of my time. I did. I had a good time. In thirteen years, I appointed twenty-six department and division heads. A couple of them were very, very bad appointments and some were very, very good appointments. I guess all of them are gone now. It's been such a long time ago.

What do you want to ask me at this point?

DT: When you were looking into the faculty practice issue, did you have any other institutional models to go from? Were there other institutions that were trying to adopt the same kind of policies?

RH: Well, that's a good question. There was a lot of this kind of turmoil going on in all medical schools. The most prominent one—I don't think I ever really wanted this particular pattern—was the University of Chicago that had system where its top professors were really full time. They didn't get any income, not that they didn't have patients there. They were paid top dollar, which then was \$25,000 a year—not exactly top dollar today.

[chuckles]

RH: I admired what they were able to do. Various other institutions had plans where the income was shared in one way or another. I never was one who felt all professors ought to be paid the same. Although, I was accused of this, I never felt that no professor ought to make more than the dean made. I really wasn't paid very much by today's standards. All my background was in internal medicine, and I always had kind of an admiration for the surgeons, the things they were able to do, so it never bothered me that surgeons made more than people in internal medicine. I just thought that they ought to be taking home somewhat less because some of it belonged to the university and that they ought to be making better arrangements to incorporate their patients into their teaching. It ought to be understood that they weren't to take patients who were unwilling to be part of the teaching program.

Then, under the influence of particularly the two guys I've mentioned, I also came to the notion that we ought to be offering health care instead of a cafeteria of the best cataract surgery or the best surgery for congenital heart disease and so on and so forth. We weren't really teaching our students about the scope and the breadth of medicine. In this, I was really right. People have told me that since. The university, which belatedly has moved in that kind of direction, many years after I was plumping for it did establish a faculty practice program, and I had to laugh. [chuckles] They were totally unprepared for the 1970s when health care costs were really zooming, and manufacturers and other industrial outfits which had been more or less willingly carrying the burden of the health care for their employees were finding it increasingly difficult, and they were looking for places where they could bargain. They could go to the Mayo Clinic and they could... I think the Mayo was one of my ideals, actually, and that's what I'd seen. They could go there and they could cut a contract...go to the U, nothing. Nobody could speak for the U. I think they lost a decade in being able to compete. The medical market was vastly changing.

I don't know whether that answers your inquiry or not?

DT: Yes. Certainly.

Actually, you mentioned the full-time system that was at Chicago. I've seen some documents in the archives. I think it was 1966 when two departments, Pediatrics and Physical Medicine & Rehabilitation, adopted a strict full practice system. I wonder...how did that come about?

RH: That was my fine Italian hand.

DT: [laughter]

RH: I think Medicine did that, too, with one limitation, one practitioner.

Well... I kept saying that strict full-time was a misnomer, as it applied to people who were making two, three, ten times as much with their private practice. They weren't full time. I offered a system that distinguished between strict full-time and geographic full time. The bigger earners wanted to stay in the latter. But it was appealing to Physical Medicine and to some extent to the Department of Medicine because the carrot in it was that almost all these people were involved in research projects, and there were funds from those, and I could boost their salaries by an increment if they agreed to be strict full-time. It would include their own earnings, as well. If a guy was making maybe \$15,000 a year and making another \$3,000 in internal medicine, which didn't pay all that much—I was there; I wasn't cleaning up exactly—and if he was giving a quarter of his time to a research project, I could put the \$15,000 and the \$3,000 together with the \$5,000 and call it a strict full-time salary, that was pretty good. It was appealing. One of the benefits of that was that that became his university salary and his retirement was based on that. So it did have a certain appeal. I was going around Paddy's barn trying to get a strict full-time.

I don't know if we're ready yet to talk about my replacement in the Department of Surgery?

DT: We can talk about it. Go ahead.

RH: In 1968, Wangenstein [Doctor Owen Wangenstein] retired. I knew that his retirement was really a bag of worms for me. So I appointed really a blue ribbon committee headed by Doctor Robert Good, whose name has probably come up.

DT: Yes.

RH: He was the closest we ever came to a Nobel Prize winner. His bid for that was ruined by one of his associates who forged information, so he was taken off that list. Bob Good was a very, very bright guy and a tremendous researcher.

He headed the committee. Arnold Lazarow, professor of Anatomy, was on it, and several others of our best professors, and, then, there was an outsider, Doctor Bert Dunphy of the University of California, San Francisco [UC-SF]. I knew I had a problem on this, because we had some people on the scene whose names were very well known: Richard

Varco, C. Walton Lillehei, and a couple of others...F. John Lewis—although, maybe Lewis had left at that time. Anyway, the committee, interestingly enough, never considered Walt Lillehei; although, his name was the most prominent name. They never considered him because it was felt that he was totally disinterested in any kind of administration. We recognized that a department head is not just an honorary title. It ought to be somebody that knows how to run something and have an interest in the whole department, and, indeed, in the whole school, and ideally in the whole university. But that's grasping for a lot more than we could get, I'm sure.

[laughter]

RH: It did think very highly of Richard Varco, and it also named Doctor John Najarian as a possibility. Najarian was the second in command out here at UC [University of California], headed in the direction of being the ultimate head of that department. He had a house on top of Telegraph Hill [in San Francisco] that commanded 270 degrees of the bay area. The other thing that Najarian had is a real background in immunology besides surgery.

I should offer you some coffee.

DT: I'm fine. Thank you.

RH: Are you sure?

DT: Yes.

RH: We'll be going down and eating soon.

The committee perceived that, and I did, too... I saw this happening with transplant surgery. We hadn't been in it very much. We'd been in open heart and doing all those magnificent things, but transplant had not been our baby. As all the congenital defects got fixed, and there wasn't so much of that, it seemed to me that we were going to be in the transplant business. Well, the committee recommended Najarian, but they *really* didn't think I could recruit him. So they thought they were recommending Richard Varco, and, Varco, of course, I admired his skill, but he was one of my really staunch opponents on this private practice matter. Well, I came out and visited Najarian, whose wife had come from Minnesota. To everybody's surprise, I managed to convince him to come to Minnesota. Now, he was going to come and did come on a strict full-time basis. We paid him a salary, fifty thousand bucks—a lot more than I made; a lot more than anybody made as far as a university salary. That was to be his SFT [strict full-time] salary. So he came. You know, I'm sure —your archives tell you—a lot about John Najarian and his triumphs and tragedies.

My particular tragedy was within four months or so after he got there. He joined the opposition to me, and never did much of anything for me after that. But he certainly put

transplant surgery on the map at the University of Minnesota. I guess he's still around and still operating some.

DT: Yes. I definitely hope to talk to him.

RH: It would be interesting to get his slant...

DT: Yes.

RH: ...and what he says about me.

[chuckles] I had an interesting experience out here the first year I was here. He came back and gave a talk at UC-SF. It was the fiftieth anniversary of his graduation. He was a big time doc and came out. I went to that talk. A doctor around here helped me get there. He saw me in the room and said, "Humph. Hi. You're out here?" That was the end of our conversation, the totality of it.

DT: Wow.

RH: Where do we want to move now? What's coming up?

DT: Do you know why he turned against you?

RH: I don't know. I really don't know. I assumed it was by virtue of Varco's influence.

DT: For this strict full-time system was there more support among the faculty for that or the opponents that you'd had earlier in the 1960s, they still viewed it...?

RH: No, they didn't go for that at all. The main ones [that went for it] were the ones that you named, plus the Department of Medicine. I think the Department of Medicine went for it okay, because they had something to gain, except Doctor B.J. Kennedy. B.J. was really the grandfather of the field of oncology and did a lot in the field. He was making big bucks the way the surgeons were, so he was an exception to that.

DT: How was the Medical School able to resolve, if it did, the fact that with declining county patients...? How did you resolve the issues of having enough patients to be teaching with?

RH: I don't think we ever did resolve it very well. I have no idea what goes on there today, because a lot of factors have come in, not just the factor of payment but the factor of getting people in and out of the hospital so fast, which is necessary and has many good things about it. We kept a lot of people down in bed for far too long. But it did have the good effect of allowing a medical student to get acquainted with a patient and know what their aspirations were. I don't see how anybody does that. I don't know how this has been resolved. I don't claim to have resolved it by anything I did.

We did develop what was called the Comprehensive Clinic under the direction of Doctor Magraw, which brought together the various specialists in a clinic that tried to be *the doc* to patients. It had varied success, and it wasn't well thought of. It was thought of by some of the surgical specialty areas as kind of playing doc, sort of silly. They weren't all that keen on it. But I think it accomplished some things.

Dick Magraw himself was and is a very interesting character, a Quaker, and a Quaker who is so absolute in his feelings about things. [chuckles] He and I had *something* of a falling out, because he thought I didn't support him as much as I should have. And, of course, I thought I did. I thought I was doing all that I could. In particular at one point, he wanted to be named an assistant dean. He was head of the Comprehensive Clinic, and he was a professor of Psychiatry and Internal Medicine, but he wanted to be assistant dean. I said, "No," because I didn't want the Comprehensive Clinic being run by the dean's office. I already had enough slings and arrows being shot at me.

[chuckles]

RH: I didn't want the dean's office to run it.

Well, he left and went to do different things and had a very interesting and varied career with some ups and some downs, a lot of disappointments because he couldn't carry out all of the stuff that he saw as needing to be done.

When do you want to stop for lunch?

DT: Whenever you want to take a break is fine by me.

RH: Well, I'm about to launch into Act III, and it's going to be, I suppose, fairly long. I don't know whether you want to do it now or take a break.

DT: If you want to take a break now, that's fine.

RH: Let's do that.

DT: That seems like a good breaking point.

RH: Yes.

[break in the interview]

DT: I'm wondering if you could say a little bit about how medical education was financed during your deanship...how much state funding and federal support, and the likes.

RH: I can't remember exact figures. What I do know is that at Minnesota, it wasn't funded very generously, even though the legislature thought they were funding it

generously. I remember a couple of comparisons that I made when people wouldn't believe me. I had some figures—this would have been about 1968, I would say—that Wisconsin put four times as much money per student into medical school and even the University of Mississippi put more per student in than Minnesota.

That was of some moment to me because, at this time, another of my problems was surfacing. The legislators were saying that all of our graduates went off somewhere else and they weren't doing the job in Minnesota, and Black Duck [Minnesota] couldn't get a physician. So I was supposed to produce that. I had had to cobble together a program. I did it by... You probably couldn't get by with it today. We were pretty good at getting research money, and research grants always had a segment in them for x amount of time for the chief investigator and for some other people. I was pretty good at jockeying those funds around. I can't really remember how I did it.

[chuckles]

RH: You sure couldn't do it today, but I was pretty good at getting those somehow or other into salaries combined with the funds we did get, and I put together a program, which I thought was a reasonable program.

In 1968—this was one of my accomplishments—we'd been under fire for not turning out enough doctors and not enough of them that would stay in Minnesota, so we made kind of a proposition that we would get a certain amount for some new buildings and we'd increase our class size from its nominal 100 to about 150, and we did so. Your records will probably tell about that.

DT: Yes.

RH: I may not have the numbers exactly right. That program passed the legislature, I think in 1968—it's possible it was 1967, but I think it was 1968—and was one of my accomplishments. We had to work harder for it. We had to take more students in. But we got somewhat more money, so that, in a way, eased things a little bit. I never considered us especially well financed by the state.

Along about that time—I don't know whether the records you've reviewed showed this or not—there was a move to establish a medical school in Saint Paul.

DT: Yes.

RH: That was a challenge. They wanted to use the old Saint Paul City Hospital. I think it was still known as Ancker Hospital, which had been, in part, used by the university's teaching program; although, there was such antipathy between Saint Paul and Minneapolis that we were always sort of unwelcome there. But they needed us. They were hoping for a Saint Paul Medical School so they could kick us out of Ancker. I was opposed to that. I didn't think the city could support two medical schools. And along

about the same time, the Mayo Clinic was embarking on a program to develop a medical school, and I thought that was fine.

Then, one of the things I had talked about was having a two-year medical school in Duluth, but I had it the other way around. I knew a group of Duluth physicians were very good, the Duluth Clinic, a couple of good hospitals, and I thought that we could increase our basic sciences and send students up there to Duluth for their clinical work. Well, they established the Duluth Medical School, but they did it the other way around, and they succeeded. I think they've done a pretty darn good job in having basic sciences and sending them down here, but they still manage to inculcate in those students, as far as I can see, the notion of going back into family medicine in the northern Minnesota area. So I salute them for that. Anyway, there, the state was supporting medical students in Duluth and Minneapolis. I think they popped for something in the Rochester School of Medicine, too.

DT: Yes.

RH: As I recall, it was an amount of money that I would have been glad to have in Minneapolis.

Those were some of the things that were happening locally in the late 1960s, and there was a lot more going on in the world and in the United States and in the medical field, and that's Act III.

DT: Right.

RH: Are we ready to go to Act III?

DH: We can go to Act III.

RH: Okay. All of the nation's large medical schools were going through a transition and becoming medical centers encompassing other units, and the deans were becoming vice presidents. So they were undergoing this kind of reorganization, and Minnesota was no exception. This was going on.

I was pleased to see that you correctly identified me as the dean of the College of Medical Sciences, which I was.

DT: Yes.

RH: I was never *officially* dean of the Medical School. I had the School of Public Health and the School of Nursing and the hospital under my purview. I felt that, in effect, I had been sort of vice president or provost for the health sciences, and I felt that when they formally went to that that I should be named that. For two or three years, I'd really been doing that more than I had been dean of the Medical School. Mead Cavert was sort of the executive officer of the Medical School, and I was out raising money and talking to

various groups and doing more of this kind of thing, and I was dean of the College of Medical Sciences. Only three people have held that position: Richard Scammon, Harold Diehl, and I.

By that time, Mac [Malcolm] Moos had become president of the university. He was an affable guy, a good writer, good wordsmith, but not a very strong president.

I had these two strikes against me. One, my name was mud in most of the clinical departments, and I hadn't been able to shake that, even though I hadn't done anything about the private practice issue for probably five years. The second thing was another phenomenon that was coming along and that was that the general practitioners of the state were flexing their muscles. They were saying that the university had given them short shrift, and they weren't properly appreciated when they referred patients to us, which was partly true—I had tried to make some dents in that, but failed—and that we taught people just to be specialists and so on. So their ranks were growing. At the outset, they were the Academy of General Practice.

Subsequently, that group went on to be the Academy of Family Practice or Family Medicine and set up their own standards of post-M.D. training and have been reasonably successful; although, I'm told their ranks are falling now because their specialty didn't have money, which is the story right along. The guys that hold the scalpels make the money.

DT: [chuckles]

RH: Anyway, that group was banging the drums for a Department of General Practice or a Department of Family Medicine. They were, by that time, willing to take on that title within the Medical School. They saw me as the obstacle. I was the dean who wouldn't permit that. So that was strike number two against me. They had evolved a fair amount of public support for their view, and they had elected a member of the Board of Regents whose job it was to unseat the dean, Doctor Herb [Herbert] Huffington. Has he been in your records?

DT: Yes. [chuckles]

RH: Okay.

All this was boiling in the caldron as we were reorganizing. Mac Moos told me that my position as dean of the Medical School was secure. He didn't even realize there was a difference between dean of the College of Medical Sciences and dean of the Medical School. That was secure, but as far as being automatically moved into the office of vice president for Health Sciences, I was free to apply for the job, but that was all he could say. Well, to me, that was a dilemma. I'd been in the office ten or twelve years by that time. I was knowing that I probably would not want to stay in any kind of office like that for as long as my predecessor had. I saw that it was time to move on, but I didn't want to

right then. I wanted to be appointed to this post that I saw coming and hold it for three, four, five years. I inferred from the things he said that I probably wouldn't be selected.

Then the specter arose of somebody being appointed with whom I couldn't work, and, indeed, that happened. So I ruminated long and hard about this. In fact, I went out and visited Met Wilson [O. Meredith Wilson], who had then left the presidency and was retired out here. He'd never been particular friend of mine, but a guy whom I admired for his brains and his ability. I wanted to see what it was like to give up a job that had some stuff associated with it, whether you could get used to opening doors for yourself and so on. He said, "Yes, you can. Other things will come up, and you won't worry about that stuff anymore." So I went back and about February, I wrote a letter—I think I have a copy here—to Mac Moos and said that this organization is underway and will almost certainly do thus and such. It will include a job as vice president or provost of the Health Sciences, and a dean of the Medical School, and I didn't want to be considered for either job. So I left. It wasn't all that easy, but I was glad I did it, and it worked out well for me. I took a full year sabbatical at full pay. They were nice to me in doing that, so I could live. I didn't have to scrounge for the rest of it. The full pay wasn't all that great.

[laughter]

RH: My newspaper tells me that the current dean of the Medical School is being paid exactly \$200,000 more than my top salary was.

In any event, I took a sabbatical, and spent it mainly in Europe. An old friend and resident colleague at Minnesota, a man named Paul Frick, was Swiss in origin. He'd gone back to Switzerland where he was head of medicine at what would be the county hospital at Zurich. I settled down there. My German was okay so that I could understand things. I couldn't sit down and speak apart from, "Where's the bathroom?" But I could understand things. They had an excellent library, and I began learning about medicine again. For thirteen years, I really hadn't read anything about medicine, so I picked it up and learned about medicine. I didn't know what I was going to do. I didn't have a job that suited me. I had tenure and could return to the Medical School, but that wasn't very appealing. I didn't want to do that.

I need to go back a little bit and tell you another thing that had happened, a semi-black mark. Along about the time of 1968 and all the rest of this was going on, the School of Nursing had been moving in the direction of taking its students away from the bedside and putting them into classrooms and teaching them about other stuff. This had been going on and been sort of distressing. When that year's group came to their state board exams, twenty-five percent of them failed of the University of Minnesota School of Nursing. I and others felt that was a black mark, but the School of Nursing faculty said, "The exam is wrong. They're testing the wrong thing." So I relieved the director of the School of Nursing, whom I had appointed. I relieved her of her job. That was a black mark on me in nursing schools everywhere.

During the summer after I had left the office, but before we went to Europe, I visited a couple of other institutions with respect to the possibility of administrative jobs, but in a couple of them I was a stalking horse for a guy who was already there who was going to be appointed. In at least one and I think a couple places, I was blackballed by the head of nursing at that institution, because I had done such a dastardly thing. When I left, I thought I'd probably go to some other administrative post, because my leanings had been administrative, as I told you at the outset. But I wasn't offered or thought about very seriously for either of those jobs.

So I went off to Europe and gradually began to get familiar with medicine again. I had to learn a *hell of a lot* about the field of immunology, which had exploded. The words were even different. I had to get a whole new vocabulary.

Along about March—we were there until the end of June and spent the last three weeks in England, by the way—the Northwestern Hospital [Minneapolis] called me and asked me if I would be interested in being director of Medical Education there. Now, my old mentor, Cecil Watson, professor of Medicine when I was a student and when I first became dean, had retired a couple of years before mandatory retirement, had gone to Northwestern Hospital to establish a residency affiliated with the university. I had sort of greased the skids for that, because I knew he wanted to get out, and I thought that would be a good job. I never had any other idea about it, but this call came. Would I be interested in taking over? Well, I *was* interested, and I came back. Cecil was there, and he'd really set up a nice program. Having been his student and then his superior, I was once again under him. For a year, I was second in command. But the poor man, despite his brilliance and his energy keeping on working in his lab—he ran a wonderful lab there at Northwestern and so on, but he was getting Alzheimer's, really severe Alzheimer's. I mean, it moved pretty fast, and he knew it. That's why he was eager to get me back there. So the next year, I became *his* superior again, and he deteriorated, went downhill. So I was there.

I managed to take my boards again. I'd learned enough to take my boards again and passed them pretty well. But I was never a really great teacher. I was fortunate to have Doctor [Claus] Pierach, whom you know...

[chuckles]

RH: ...and a couple of other guys who were very good at the bedside. They helped me over some of the rough spots. I was there because of my previous title; that was presumably a crown in their cap.

I never ended up being particularly proud of the job I did there. We did all right. We had some good people, and it was interesting in this way, that it was a time when more women were getting into medicine and, yet, they were still not welcomed at many of the best internships. So we became known as a place that welcomed women. My best residents were women. I had a bunch of women there, and they were really good. We

welcomed them, and they did really very well. We had a program that I think was a good program. Almost all our candidates passed their American boards well.

At about the tenth year, I was getting kind of tired and uneasy of this. We had a time when there were two or three failures in boards, and I knew it was time for me to get out. I'd thought I would step aside and become one of the teaching staff. By that time, they had four or five people on the teaching staff. They'd done a good job of supporting this.

One thing I did there, and one of the reasons I was brought there, is establish a surgical residency program there, but I don't think it lasted particularly long. Anyway, I did do that.

I wanted to step aside. They brought in a guy and the first day he was there, I knew I couldn't work with him. So I decided I had to leave. Fortunately, for me, I've had a lot of good breaks in this world. I'd been working for ten years or so as kind of a guest editor or a helping editor of *Postgraduate Medicine [Magazine]*. You know the magazine, because you wrote about that.

DT: Yes.

RH: I had been at their editorial meetings and knew the editors who really put it together out in Edina [Minnesota]. They'd had a full time editor in chief for a while. The first editor of the publication was Doctor Chuck Mayo, the son of Charlie Mayo, but he wasn't a paid full-time person. The second one was a guy named Allen Ryan, whose interest was in developing a sports medicine magazine, which he did and moved on. The third man was a man named Tom Fleming, who came from the East. He was good; he did a good job, but he was hungry for the East. So just about the time I was in this dilemma, he had announced that he wanted to leave. I had been asked, when he came two years before, if I was interested in doing that. I said, "No, I'm happy doing clinical medicine at Northwestern." By the time that happened, *I was interested*.

[laughter]

RH: I went there, and I spent five and a half years there. Those were the *best*, the happiest professional years of my life. But the irony was that I had to have had all these other things in order to do a good job—and I did that job well. I gave myself an A on that, and I gave myself a B- at Northwestern Hospital, and a B- at the university, but later events, made me raise that to a B+, after the newspaper articles of 1993 came out.

[chuckles]

RH: My background and interest in words and writing were a perfect match with my knowledge of medicine. I didn't have to do writing there, except I wrote a column from time to time. The associate editors did all the real editing, but I had to get to know the people that might write an article and get them to do it. I traveled around quite a bit and

had a really good time. I had just a *wonderful* group of colleagues, all women—and they loved me.

[chuckles]

RH: And I loved them. If I'd said, "Lie down on the railroad track," they'd have done it. It was really a wonderful experience and to be part of the business world after I'd been in the academic for so long was interesting to me, to see how the business world did it and the academic world did it, vice versa in some respects. Those were the kinds of things I did.

Then my wife got Parkinson's and, after about a year, I decided that... She was quite well at that time. She had it for twelve years, and eight years were pretty good. The first four years, we traveled and did good things. I was glad I quit.

Also, of course, as things happened, that kind of journal just about went out of existence, and there's no need for it anymore. In fact, *Postgraduate Medicine* and all of its real competitors have folded up their tents at this point.

There was one other observation I was going to make. I told you I did manage to do the boards again, so I was pleased that I was able to do that. I wasn't any great shakes as a teacher.

[chuckles]

RH: [pause] Well, that's my story.

DT: Can I ask you some follow up questions?

RH: Please do.

DT: First of all, do you recall the name of the director of the Nursing School that you let go?

RH: Yes, Edna Fritz.

DT: I've seen her name in the record.

RH: You've seen her name, yes.

DT: Related to the Nursing School, I also saw—maybe this is related to what you just told me—that the practical nursing degree program was eliminated in 1966.

RH: I'm hazy on this. Did they actually have a practical nursing degree program, too?

DT: I think so. That's what I understood from what I've seen in the archives, at least.

RH: Okay, that may well be. What I do know, what I can testify to—I think I mentioned this—is they moved farther and farther away from the bedside. They saw nursing as more educational, supervisory. Their program was a five-year program. They were encouraging their graduates to go into still further programs. They were certainly getting away from carrying bedpans and that kind of stuff. Now, it may well be that you're right, that they had an LPN [licensed practical nurse] program and discontinued it. It would have been in accord with how the nursing faculty felt. But I don't specifically remember that.

DT: That makes sense though with your description of how things were changing. My sense was that the Nursing School wanted maybe it was Duluth, but other schools and junior colleges to be responsible for practical nursing training.

RH: Yes. I do recall that. That was being fobbed off on the lesser lights.

DT: If I can turn back to the reorganization of the Health Sciences and the creation of the Health Science Center?

RH: Sure.

DT: Could you describe to me a little bit more in detail about why the expansion and the reorganization happened?

RH: I guess the best answer I can give is not really an in depth one. It's really that that's what was happening everywhere else. I'm not sure that I can tell you the things that made this essential. One of them was that nursing was tired of being under the dean of the Medical School. The real irony *now* is that they're back to square one.

[laughter]

DT: Right.

RH: I emailed President [Robert] Bruininks about this, but I never heard from him.

I also remember one other thing. I'll return to that.

So that was one of the things: the nurses wanted to be equivalent, so they saw their role as approaching that.

I think, to some extent, the same thing was true of pharmacy. Pharmacy was searching for a new identity. They no longer rolled pills and put stuff together. It was a little hard to just hand out bottles of Secinol and so on. They went forward with the Pharm.D. [Doctor of Pharmacy] Program and made their people into people that really knew something about antibiotics. I saluted them for that, because they became very good.

Although, the doctors often resented them, they really did know more about the effects of medications than the docs did. So they were pounding on the gates, too.

Then I think the other thing that was happening was that hospitals were becoming into real focus. They were the ones where the costs were going up so. They were the ones in which all the exciting stuff was going on. Their identity got bigger and bigger.

Now, one of the things I've said, and I've said it in some of these, and I've written it in letters—I'm pleased to see I wrote it thirty years ago—is that the Medical School dean needs to have purview over the hospital or the clinical faculty will consider him or her irrelevant. That is maybe the bottom line that Bruininks has come to in what he's doing now. I don't know. He hasn't confided that in me. I know that that balance didn't occur after this reorganization. But, I suppose, to turn back to the 1950s, and in the 1960s in particular, the reality of hospitals was coming up, and they really needed top administrators, and, in many instances, a hospital administrator made more than the dean, so people began to come up with the idea of putting all these health sciences together. It was going on everywhere. I was not unaffected by it. As I said, I had done this.

I was also, at that time, named the elected chair of the Association of American Medical Colleges, so I thought I had some standing in the field and some reason to be appointed to the post. I felt that it wasn't in the cards. I'm pretty sure the nurses didn't want me and I had a feeling that Larry [Lawrence] Weaver, the dean of Pharmacy, didn't want me either; although, he never expressed that outright. Have you heard about him or talked with him?

DT: I haven't spoken with him yet. I've read an oral history that he did in the late 1990s. I skimmed through it. He talked a lot about the development of the Pharmacy program and getting...

RH: Things I've said?

DT: Yes, awarding the doctorate in pharmacy and changing pharmacy practice.

RH: Yes, I think they put that up front, but I don't think he was ever very fond me. I don't know why. I didn't step on his toes, particularly.

Of course, dentistry wasn't in it then either. They had prided themselves on being independent. To me, it was a natural that they be part of health sciences if we were going to have health sciences.

The other things I was going to tell you, a couple of ironic things... I told you that I was a drug on the market in 1970 when I was kind of looking around for another post. But after I got back and I was at Abbott Northwestern, had been there, I must have had fifteen letters inquiring about was I willing to be considered as provost or head of Health Sciences or whatever. Some of them were of the stalking horse variety, but there were a couple real ones. In one case, it would have been a place I would have been interested in,

except, by that time, I'd settled back into clinical medicine. In Minnesota, we'd built a place at the lake, and I loved it there and I loved what I was doing, so I said, "No."

The other interesting thing was that within a year after we were back, my wife, Lorraine—my first wife—and I invited Mac Moos and his wife out to dinner. It was a *fascinating* time. Unbeknownst to us, they had separated by that time. He told me he was sorry that he hadn't backed me.

He was not a strong president, but a very good wordsmith. He was the head of the Ford Foundation and he, also, was a speech writer for [President Dwight D.] Eisenhower. He wrote Eisenhower's famous military-industrial complex speech.

DT: Really? Fascinating.

RH: Yes. He was a very able guy in his field. He was an example of the Peter Principle: you rise to your level of incompetence.

DT: [laughter]

RH: Another friend of mine, not a close friend but a good friend, developed the Retep Principle, the opposite of the Peter: you descend to your level of competence.

[laughter]

RH: I probably exemplified both of them.

DT: [laughter]

One of the things that struck me from the archival material is the discussion of a team teaching approach. That seemed to be one impetus behind the reorganization. Is that something that you experienced?

RH: I recognize the term, but I never fully understood it. I think I heard the nurses use this a lot more than any of us in the Medical School.

We did, in my tenure in the Medical School, revise the curriculum. I think it was a good revision. At the same time the nurses were getting farther away from the bedside, we put the medical students closer to the bedside. I think that was one of my accomplishments. I made a lot of good appointments and I made a couple of really bad ones, *really* bad ones [whispered].

I appointed a guy as head of the Department of Psychiatry who was terrible.

It was a time in psychiatry where, as in so much of medicine, a lot of things were going on. It was a time when there was a branch of psychiatry that was getting more and more involved in medications and chemical treatment of psychiatric disorders. There was

another group of psychiatrists who were moving in the direction of social psychiatry and treating the whole village. [chuckles] There was a guy who'd been an Army major and he had been instrumental in developing a new city outside of Baltimore. I've forgotten the name of it; I used to know the name of it. Anyway, he'd been involved in that. Since I was stirred by the 1960s... I didn't smoke pot, but I grew my sideburns long and all that.

DT: [chuckles]

RH: I appointed this guy, and he was a *dismal* failure. I mean, he was really bad. The guy that I turned down, a guy named Bunny—Jim Bunny; I'm not sure it was Jim—was of the other school. He'd been working at the NIH [National Institutes of Health] on the chemical aspects of psychiatry. He didn't win a Nobel Prize but he got some big prize, so I kicked myself for that.

The other bad appointment I made was hospital administrator, Ray Amberg who was the long time hospital administrator. As far as the legislature was concerned, he was a great lobbyist for the U. As far as they were concerned, he ran the medical enterprise. He came to mandatory retirement age, and he retired. An interim appointment was his assistant, Gertrude Gilman, a very nice lady, and she did a nice job for a year while we were looking at other people. I was swept up in the way things were moving in the modern world, and I selected quite a young guy, who seemed to embody this let's-get-out-and-help-the-community sort of business. His name was John Westerman. His name is probably in there, too.

DT: Yes.

RH: He hung around for maybe five years. I don't know. His personal life changed. He divorced his wife. They had a daughter who was killed by a hit and run driver who never was found, and their marriage broke up.

DT: Yes.

RH: He wasn't a very good hospital administrator, but the thing he did, almost immediately when he moved into that role, was he turned against me and bad-mouthed me to the extent that I kept hearing about it when I was over in Europe, and I certainly heard about it when I got back. I never figured out why, but he did. I don't know what's happened to him.

DT: What was the general attitude of the faculty in the Medical School towards the reorganization of the health sciences?

RH: I think they welcomed it. I don't think it was something that they were standing there waiting to applaud. My impression was that some of the people in the other units were more interested in that. I don't think the faculty felt that it affected them all that

much. Some of those in the clinical departments felt, gee, it was a good time to get rid of Howard as dean.

DT: [laughter]

Changing tack a little bit... You talked about the relations with the other units in the College of Medical Sciences. I was wondering if you could say a little, maybe, about the College of Biological Sciences and the relationship between the Medical School.

RH: I never had anything to do with that. I knew Dick [Richard] Caldecott [dean of the College of Biological Sciences], because I'd known him before. In my tenure, I never had anything to do with the College of Biological Sciences, and I wasn't sure what their marching orders were. I knew they existed. While I was there, there were some beginnings of Engineering working with some of our people, but they weren't people in the College of Biological Sciences, I don't believe. Were they, as far as you know?

DT: It looked to me as though there was discussion about whether—I think the Department of Microbiology was one area in particular—they should be under the College of Biological Sciences or whether there should still be a medical microbiology unit. It seemed like there was a lot of discussion about how those departments would fall under Microbiology, but, yet, have units in the Medical School, whether there should be two, whether there be one.

RH: Okay. I see what happened, and I understand that in a way. Turn the clock back a while. When I was in school, we had the College of SLA, Science, Literature & Arts, and that included physics and chemistry. There was a battle going on for several years whether they should be in Engineering or in the Arts College. The Arts lost, and they went with the other, so it became the College of Liberal Arts. It's the same kind of battle. I can see how that would happen. But I had no part of that.

DT: Okay.

RH: I was not involved.

DT: I wonder if you'd be able to say a little bit about the influence that the introduction of Medicare and Medicaid had on the Medical School. You've talked somewhat about the county patients before Medicare and Medicaid but...

RH: Yes. I think it had a *big* influence. It had begun before that. It had begun in the 1950s when people began to have insurance. Of course, the first insurances were really surgical indemnity insurances. They paid for a gall bladder operation and didn't pay much for internal medicine services. But, they were growing. The 1950s were a time when the nation was wealthier, and there were fewer poor people stuck back on their farms. Medicare put a *whole* new face on it, because here were a bunch of *old* people that were impecunious before, and now they had something backing them up. So they were coming in with money attached to them. Those really did change things and

changed the attitudes of doctors towards their patients. The whole business of trying to maintain teaching in such patients is, I think, difficult. I don't know how it's accomplished now, because I'm so far away from it. It was one of my points of concern when I spoke out about the private practice. I just thought we ought to be able to incorporate. We *had* to. This was our teaching ground. This was the stuff that was used. I would say, "Yes, Medicare made a big difference."

Another kind of difference it made is that, prior to that, many docs felt a need to give some of their time to charity and gave free service. My own father spent six months a year on fracture service at the old Ancker Hospital in Saint Paul. That was the public service that he did for half a year at a time. Most doctors did that. We also gave professional courtesy to another doctor or to a doctor's wife, and we gave some courtesy to the clergy. Well, that all went out the window. You charge a doc just what you charge anybody else and the doc's wife and so on. So it changed the nature. The only way a doc can do the real kind of charitable work or as some would put it, "God's work"—I'm not of that persuasion particularly, but some are motivated that way—is to go on a mission team and you either leave your practice for six months or a year or forever. But you can't any longer do it out of your back pocket very readily.

DT: That's an interesting take. It's another perspective on the impact of Medicare and Medicare.

RH: On doctors and what they do, that's right.

DT: Yes, absolutely.

You'll let me know if you get tired.

RH: You're the one who is going to get tired. I'm chatting up a storm.

[laughter]

DT: Oh, no, this is wonderful. I'm happy to keep you keep going as long as you're willing to.

What about other kinds of federal legislation in the 1950s and 1960s that influenced the running of the Medical School?

RH: There was a lot of legislation, and, in some ways, it affected medical schools. I'll tell you to the best of my ability. In the immediate post-war period as far as health was concerned, there was a big push to provide more and to have care available throughout the nation. There was a senator named Burton [Harold H. Burton] and a congressman named Hill [J. Lister Hill]. I think that's the way it was—the Hill-Burton.

DT: Yes.

RH: The Hill-Burton programs put *a lot* of money into two things. One: they built all sorts of hospitals in small communities. That proved to be a mixed blessing at best, because, suddenly, we found ourselves with thirty-bed hospitals, and they couldn't afford an MRI [magnetic resonance imaging]. That was a noble thought, but it was not that helpful in accomplishing the mission. I don't think that particular program directly affected the Medical School.

But the development of NIH, which started out as the National *Institute* of Health and spread out to the National *Institutes* of Health, they developed all sort of programs. They built laboratories. They picked scientists to head programs. They gave these research grants. In some instances, they selected scientists to support for the rest of their lives at what, then, was thought to be a good lifetime support of \$25,000 a year. We had a couple of those at the University of Minnesota. So it did affect it. It had a good effect on lots of things; good things came out of NIH's programs. But it, also, took doctors' attention away from (a) medical care and (b) teaching or (a) teaching and (b) medical care. It changed the kind of people and it changed what constituted a good medical school, because now the ratings depend... Minnesota is fighting this battle—that's what the recent change is all about, I'm sure—of trying to be in the upper echelon. That's all measured by how many grants you get. One can argue whether that's good for medicine or not. I have two minds. I like stuff that grew out of that, but the German model of having research institutes and clinical schools has something to say for it, too. Yes, it changed the kind of faculty we got. It changed the people we recruited because you wanted to get somebody who could bring in money to augment your institution.

As I told you, I was pretty good at scrambling this money and making use of research money to get it into paying faculty so I could up their total salaries. I don't know that that can go on anymore, because the whistle kind of blew on that. I had some faculty members who had signed away a hundred and forty percent of their time, ten percent on this grant, twenty-five on that and...

[laughter]

RH: According to them, they weren't giving any to the Medical School or to sleep or whatever. In any event, it really did change the nature of the people who came aboard. I think they became less interested in the teaching.

There's a book called *The Uncertain Art* [:*Thoughts on a Life in Medicine* by Sherwin B. Nuland]. My daughter gave it to me. I sent it back to her because I thought she should read it. The first essay in it is about how medicine is an uncertain art. Many people think it's precise, but it really isn't, and all doctors have to deal with a lot of uncertainty, which is difficult. One of the other essays in there is on this thing I've just mentioned: the loss of teaching and how practically nobody in medical school gets recognized for being a superb teacher. I think that's too bad.

Anyway, yes, these programs did affect medical education.

DT: There seemed to be a lot of attention on a perceived shortage of health care workers in the 1960s. Can you say something about that?

RH: Yes, everybody was pointing to this. We had a lot of statistics that showed that we had fewer doctors per capita than most other industrialized countries. Most medical schools increased their class size. We did sometime in the 1960s, and I told you about that...

DT: Yes.

RH: ...and how I was out there plumping for this program. It was a bit of a quid pro quo of increasing from a hundred to about a hundred and fifty. I think those are the numbers; although, they may be inexact. Most medical schools were doing that. The new medical schools were growing up. States that didn't have medical schools were developing and two-year medical schools were becoming four-year medical schools. Where George Aagaard went, that was his job there. The University of Washington had been through the same business. North and South Dakota both had two-year schools. I'm not quite certain what they are now. They used to send their students to Minnesota. So there was a lot of hullabaloo about not enough doctors.

At the same time, there was a lot of fussing about not enough general docs. I'm kind of interested to see in recent things that they're still talking about that. In fact, that's probably become even worse, because the government programs haven't been particularly kind to family practitioners or general pediatricians. Their rate of reimbursement is relatively small, and they get cut badly whenever there's a cutback as we're now facing. If you're doing big operations, you get paid pretty well. The last figures I saw about how many graduates were going into family practice was amazingly small, so I'm sure we're going to hear more on that. I think that one of the things that's going to come out of all this rearrangement is going to be more nurse practitioners who do the frontline medicine. They get very good and they do very well.

DT: Yes.

RH: Times have really changed.

DT: It seemed that related to the concerns about how many health care graduates there are in Minnesota and related to the reorganization there was the committee led by Elmer Learn to assess the physical facilities at the Health Sciences Center. Do you recall anything about that?

RH: What year was that?

DT: Nineteen sixty-four, 1965. He led a committee, which had seven subcommittees each focused on each unit of the health sciences that would assess the physical facility needs as a way of figuring out how much space would be needed if the enrollments in Medical School, Dental School and such were expanded to meet the manpower needs.

RH: I've drawn a blank on that. Who did that?

DT: Elmer Learn was the chair of that committee. I believe it was President Wilson in 1964?

RH: Yes.

DT: It was President Wilson who authorized the committee. It was somehow related to the state legislature...

RH: Pounding on the door and wanting more...

DT: Yes.

RH: Who was Elmer Lund?

DT: I should know.

RH: It wasn't Roy Lund?

DT: No.

RH: Roy Lund was head of Physical Plant. It's funny; I draw a blank on that. I suppose the reason is that somebody who is not an integral part of the Medical School would not really have any substantive kind of knowledge about how space operates in the Medical School. They're used to thinking of it as classrooms and how many you need if the enrollment in General Psychology goes from 300 to 500, and if you need four more professors, how much they need. That has practically nothing to do with space needs in the Medical School.

One of the limited powers that I had as dean... I always said that I was held responsible for things that I really couldn't change very much. [chuckles] Being dean, you didn't have a lot of power. But one of the limited things I did was I could assign space. Within certain limits, I could assign space, and I had to do that when I recruited people, how many square feet of research space you'd get. Everybody always needed more space. We would get some funds for a new laboratory and all those things had nothing to do with numbers of students, not a thing.

Then there was a move that space assignment was going to be done by Central Administration.

Oh, I know who Elmer was. I didn't remember his last name. Yes, I remember. This was the guy that was supposed to be the space czar.

DT: [chuckles]

RH: Are you sure Lund is his last name?

DT: Learn, L-e-a-r-n.

RH: Learn, okay.

DT: It's my accent.

[laughter]

RH: Elmer Learn, yes, a nice guy. I liked Elmer Learn. He was of that notion of what you need if you got 5,000 students versus what you need if you got 7,000 students and how many classrooms. The threat at that time was that they were going to take that over in Central [Administration]. Boy, that was when I began to think about I better look for different work because that was the one thing I could do that influenced people and could reward people or bring in new good people. If they were going to take that away from me, I had nothing left. Okay, I do remember that study. I didn't like it. I don't remember that it had any influence.

There were several studies that didn't have any influence. For the private practice matter, we had a committee made up of a lot of people from around the U.S. who were involved in private practice and issues in their schools. It also included my predecessor, Harold Diehl, and some surgeons from other institutions. It cost the university forty thousand bucks, and they came in and were there a week, and came up with some recommendations, which, in general, supported what I was trying to do. The university paid no attention to them.

When there were about to reorganize, they had another comparable committee of wise men and women who were going to advise them. [chuckles] They made recommendations that the university never paid any attention to. Among them, they were supposed to establish a separate school of Allied Health for certain programs like PT [physical therapy] and so forth. They never did that; they went ahead and did what they knew that they wanted to do anyway.

DT: Why do you think they even bothered having these external committees?

RH: Oh, you do that for window dressing. We see it in political life, don't we? If you're in real deep trouble and the wolves are howling from all sides, you appoint a committee to study it. Sometimes they do good things.

I think that the most influential study that I was aware of for a long time was the study that—I'm blanking on the man's name—was done before World War I, the study of medical schools.

DT: Oh, [Abraham] Flexner.

RH: Flexner, yes. Flexner's report really did change things. Schools changed. The proprietary schools closed their doors and the other ones pulled up their socks and went to work. That was a good study. For every Flexner Report, I think there are about 1500 ignored reports.

[laughter]

DT: That's a really fascinating observation, because looking at the archival material, Elmer Learn's committee looks like it was pretty influential. So this is very important.

RH: You know I drew a blank, and partly because you pronounced Learn and I heard Lund, but in part because no attention was paid to it. It didn't influence us at all, as far as I know.

DT: That's why it's so important to talk to people like you.

I don't know if you have any more that you can say about the debates and discussions around the setting up of the second medical school, in addition to what you've already said? Is it possible to elaborate more on what some of the other non-medical school physicians, like the local physicians, were thinking about it?

RH: The local physicians in Saint Paul were very enthusiastic. They saw this as their answer to the university that they didn't like very well. So, they gave quite a bit of verbal backing. I don't know if they ever anteed up any money for it. They liked the idea and the Minneapolis physicians didn't like it; although, they were not all that fond of the Medical School either. There were a fair number of Minneapolis physicians who looked at us as kind of the enemy. I think Duluth probably had a lot of community support. As I said, they did something that wasn't what I thought they should do, but I was wrong. They did a good job.

There was a big fight at the Mayo's... I was much of an outsider, so I don't know who the Obamas and the McCains were in that one. But I know that there was a group that said, "We're a hell of a good clinic and we ought to stay that way. We shouldn't mess with this." There was another group that said, "No, this would round us out as a medical institution." The first dean there I think was Ray [Raymond] Pruitt, who is quite a good friend of mine, a very, very erudite guy. I think he did a good job there. I haven't followed much of what's happened since at the Mayo. I think they do a good job. One thing: they've been freer to accept people from everywhere, and I sort of envied that at one point, and they were getting more money per student than we were. But they could take them from Nevada or Canada or wherever, and we had to think long and hard before we took somebody from out of state.

DT: Why was that?

RH: Because we're a state school and we're supposed to provide doctors for the State of Minnesota. We did take some people from outside the state, but we'd hear about it. A doc from Sleepy Eye would come in and say, "Why didn't you take my son? After all, he's got a C+ record."

DT: [chuckles]

RH: "You took this guy from Ohio just because he had a 4.0 average?" Those were some of the fun things.

[pause]

Are you done asking me questions?

DT: I actually have more questions if you can...

RH: Okay. Let's do it. Then I want to show you something.

DT: Sure, absolutely.

I was blanking because what you had just said had raised a question for me and I couldn't remember what the question was I was going to ask. But, why was there so much animosity from the local physicians towards the Medical School?

RH: At the time I was in office, the animosity was that we were making incursions into their practices. In an earlier day, a day I was not on hand for, it was the unwritten assumption that university people would take private patients on referral *only* from somebody of that specialty. A urologist would get into trouble with his patient and send him to the urologists at the U. By the time I was around that had pretty much shifted, but we still clung to the notion that our patients were referred from a doctor, but not necessarily in the specialty. At that point, the downtown specialists were fussing. One of the points they were fussing about was one of the things that was part of my initial speech. They said, "These guys over here are getting their office paid for, and all of their backup is paid for, and we have to pay for that ourselves, and they're not charging any less than we are." So that was part of it.

Part of it was sort of an assumed arrogance on the part of the faculty, that they were better than the people downtown. They weren't wrong in thinking that, totally. I heard John Najarian say that the really good people are at the university and those that are not quite so good go into practice. I always rejected that notion, but, somewhere down the line, I suppose I sort of believed it—until I went to Abbott Northwestern and I saw some *really* good docs there, every bit as good as the stars at the U.

DT: How about the relationship that the Medical School had with the state legislature? The question I was going to ask before that I'd forgotten was—you mentioned how the

Medical School was supposed to take Minnesota students—did the state ever mandate how many students you should be taking?

RH: No, they didn't mandate, but they urged this. We didn't have, to any real extent, a direct relationship with the legislature. As I told you, the long time director of hospital, Ray Amberg, was a university lobbyist, an all university lobbyist but mainly on medical things. As far as the legislature was concerned, he was *the* Medical School. I had to deal with that as best I could. When I would have a chance to say to an individual legislator something like, "You know, your legislature isn't really funding us very well," he'd say, "What do you mean? We gave Ray Amberg everything he asked for." Well, what he asked for was for the hospital and very little of it filtered to the Medical School.

[chuckles] Sort of a side story to that... Bill [William] Middlebrook, who was the business vice president during my tenure, said in effect, "The Medical School has got all this research money. We don't need to give them any of our money." So I was forced to take this research money and turn it into teaching, which I did fairly well, but it really isn't what Uncle Sam intended. In the early days of NIH, things were a lot looser than they became. I know that my predecessor, Harold Diehl, could call up Doctor Frank Schmehl at NIH and say, "Frank, I need to have \$15,000 for this laboratory," and Frank would say, "Okay." But, those days were gone by the time I was there.

DT: How about relationships with the university regents?

RH: I didn't relate directly to them very often. I did at times. One of the regents was married to a cousin of mine. That didn't pose any particular problem, but it was of interest, and some people thought it had some effect, but it never had any effect. The regents—I referred to this—elected Doctor Huffington and his job was to get rid of me. But I think the regents took an interest in this private practice thing, but they sure didn't particularly support me. Part of it is that the opponents almost all had one or another relationship with a key regent. They had operated on a brain tumor or they had fixed a fracture or they had done psychiatry for people who were in the regents or who were big time people in the community who knew the regents. So I didn't have much opportunity to influence them directly.

It's interesting that when I left, my job wasn't filled for two years, as you probably know. That's how important I was or wasn't.

[laughter]

RH: When they hired Neal Gault, he had to promise that he wouldn't raise the private practice issue.

DT: Hmmm. Wow.

RH: They, later, had to do another go-around on that, as witness the events of 1993 and later. But that was their view then, that that was a sleeping dog and should be left to lie. By implication, I was wrong to have raised it.

DT: Interestingly, I came across... I think this was just in reading newspaper clippings. I have yet to look into it in more detail, but it seemed that the faculty practice issue did come up again in 1975, 1976, because, I think, the state auditor had questioned...

RH: Yes. I remember that. I don't remember the details, but, yes, that did come up, and I think they sort of punted on that one, didn't they? That didn't go anywhere.

DT: I think it was in 1975 that they changed the system a little and introduced a lawyer who would ensure that everyone was abiding by the practice guidelines...

RH: I remember that.

DT: ...and that there would be kind of a salary cap. Beyond the salary level that doctors were supposed to make, the money then would go to the university. It was a single lawyer who was supposed to ensure, survey, and make sure that that happened.

RH: I remember that now. I was interested in that at the time, that that had come up. See, one of the things that I leaned on when I made this lawyer-like presentation in about 1960 was that the law of the State of Minnesota said, "Doctors are not to charge for services at the University Hospital." So when we were breaking the law... Somebody got this person on this. I remember that now' I'd forgotten it. I suppose I laughed at it at the time.

DT: [chuckles]

RH: That didn't affect me, because I was long gone from there then. I do remember that now.

DT: Yes. It seems that as much as they tried to brush it under the table, it kept coming back up to bite.

Just maybe one or two final questions, if you don't mind.

RH: Sure. Then I want to show you some stuff that you may be interested in.

DT: Yes, absolutely.

What were relations like with the Medical School and the Mayo Clinic? I know you've mentioned the Mayo Clinic somewhat, but how were relations between the two?

RH: I think, at one point in the past, they'd been tense, and the Mayo Foundation was looked upon as interlopers. During the time I was a significant member of the faculty,

and when I was dean, I'd say the relations were quite good. We ran our graduate programs, ostensibly, together. There was less togetherness than the surface tried to present, but we ran them together. We had joint committees that read theses and that did oral exams and so on. They were looked upon as joint degrees. Mayo Clinic was more devoted to the concept of the graduate medical degrees than the university was. I suppose that was because they were trying to look like an academic institution, which they weren't exactly, and they liked that. I made a number of trips to Rochester and back. I had cordial relations with them. When I was in Continuing Medical Education, every program I had would have one or two Mayo guys on it. I enjoyed the relationship. I never crossed swords or anything.

DT: That's good.

Do you have any final thoughts on the Medical School and the organization of the Health Sciences, anything else that you'd like to share that I haven't addressed?

RH: I don't have any wise advice for anybody about how it should be done. I told you before, and I'll say it again, I'm amused that the circle has come around again and that whatever titles you put on them, we're back to the dean of the Medical School being the head honcho. I don't know how that's going to play with the School of Nursing. They will look upon it as just that rather than that he's [Frank Cerra] really the vice president.

I went along with the wisdom of the 1960s and thought that it was appropriate to bring the health sciences together, that they had things in common, that there might be some savings involved. I don't think that's really true; I don't think it can be done. But there might be some cross fertilization between various units, and that they did have enough things in common so that they deserved a voice at the table to represent them all. But it's really hard to represent all their interests by anyone, no matter what his or her background.

What do you think of it?

DT: [chuckles] I don't really understand the... Doctor [Frank] Cerra gave an interesting State of the AHC [Academic Health Center] address in which he did his best to address these kinds of questions: Why is it happening?

RH: Who gave it?

DT: Doctor Cerra.

How is it really going to save money, things like that? It was difficult to discern what was really going on. I have the same kind of attitude towards it that you do, in the sense that it's come full circle.

Rather interestingly, I was reading material in the archives from, I guess it must have been, 1957, 1958, when they were searching for the dean—you, basically. [chuckles] So

it was interesting to see your name float to the top of the pile pretty readily. One letter that I read was by Maurice Visscher to, I guess it must have been, the president. It seemed like he was the one who raised the idea of creating a center of health sciences, an institute of health sciences. He raised the idea that if that were to happen to look for someone who could be v.p. [vice president] of the health sciences. If that formation did take place, he was very explicit about how the dean of the Medical School should not be the same person. Whoever they recruited as the dean there and then, they should hire someone who would be able to move up into that v.p. role and then have someone new come in.

RH: That's interesting.

DT: On one hand that's very interesting for me, in that, Visscher seemed to propose the health sciences center much earlier, but he was explicit that the two functions should be separate.

RH: Yes. He was a great guy, a very forward-thinking guy. Of the people on the committee that ultimately chose me, he was the one most opposed to me at the outset.

DT: Oh.

RH: After I was appointed, he was probably my strongest advocate as the years moved on.

DT: How interesting.

RH: Yes. He was a very forward-thinking guy. I'm interested to hear you say what he said, because it doesn't surprise me. I don't think I ever heard him say it, but it doesn't surprise me.

Well, I had those notions, too, that we needed to have different people.

I don't know how far you go back and how much you've learned about how the College of Medical Sciences came about.

DT: I read Leonard Wilson's history that he wrote of the Medical School [*Medical Revolution in Minnesota: a History of the University of Minnesota Medical School*].

RH: Leonard's was pretty much a history of the Department of Surgery.

DT: [laughter] That's what everyone says.

RH: It wasn't really a history of the Medical School. It was good; it was interesting reading.

Did he talk about Dean Lyon [Elias Potter Lyon]?

DT: Yes, I do recall, but if you want to recount the story...

RH: Well, I don't go back far enough to know all of the things, but I know that when a decision was made to have a real medical school—this may be an influence of the Flexner Report—they got Elias Potter Lyon who came from Missouri or Kansas or somewhere down there. He was a physiologist; he wasn't an M.D. He started out by bringing in strong basic science people, really strong. I think earlier, Minnesota was known for good people in the basic sciences. Well, one of these people was the anatomist, Richard Scammon, who apparently was a very, very scholarly guy, I mean really top of the list. He was offered a post at the University of Chicago, and Minnesota didn't want to lose him, so they put together the College of Medical Sciences and made him dean of that to keep him. The story goes that he proved to be a very ineffective dean, a very scholarly man but not a good dean. The President and the Regents decided to replace him. They got together out on Charles Mayo's boat and decided to ask Harold Diehl, who was head of the Health Service, to be dean.

That was in a day when the president and the Regents could make these decisions. There were no faculty committees or any of that kind of stuff. Now, you have to have a faculty committee. Harold Diehl was dean for twenty-three years, and he had committees of three people to do major things. When I was dean, I had committees of six people. Now, they have to have about eighteen people. They have to have representatives of all the various constituent groups within the faculty.

They all have to be represented. I don't know how they ever get anything done. They sometimes end up with the least common denominator. Those words are spoken from a prejudiced point of view, I'm sure.

[End of the Interview]

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