**Seymour H. Levitt, M.D.**
Narrator

**Dominique A. Tobbell, Ph.D.**
Interviewer

**ACADEMIC HEALTH CENTER**
**ORAL HISTORY PROJECT**

**UNIVERSITY OF MINNESOTA**

## Biographical Sketch

Born in Chicago, Illinois, Seymour Levitt spent most of his early life in Colorado. He received his bachelors and medical degrees from the University of Colorado, in 1950 and 1954, respectively. After an internship at Philadelphia General Hospital and time in Stuttgart, Germany with the US Military as a General Medical Officer and a Ward Officer (1955-1957), he did residencies in internal medicine and radiology at the University of California at San Francisco (1957-1961). Dr. Levitt went on to hold all f the following positions: from 1961 to 1962, he was an instructor in radiation therapy at the University of Michigan; from 1962 to 1963, he was an assistant radiotherapist at the University of Rochester Medical Center; from 1963 to 1966, he was a radiotherapist and the chief of the Division of Radiation Therapy at the University of Oklahoma Medical Center; and from 1966 to 1970, he chairman of the Division of Radiotherapy and Oncology at the Medical College of Virginia. Dr. Levitt was recruited to the University of Minnesota as a professor in and head of the Department of Therapeutic Radiology in 1970 as well as chief of the Therapeutic Radiology Service, both of which he established. In 1997, an endowed chair in clinical radiation oncology was created in his name. He continues to be on the faculty of the University of Minnesota as a professor emeritus and also has served as an adjunct professor at the Karolinska Institutet in Stockholm since 2002.

## Interview Abstract

Levitt begins by describing his childhood and his decision to study medicine. He describes his time in the military. He discusses the choice to do two residencies (radiology and internal medicine) in San Francisco. He describes the changes that have occurred in therapeutic radiology over the course of his career. He discusses his tenure at other universities and the decision to come to the University of Minnesota to build the therapeutic radiology department. He describes using linear accelerators in place of cobalt machines at the University of Minnesota. He discusses the influence of foreign physicians on American radiation therapy and the conflicts among physicians treating people with cancers. He also discusses the culture of the medical school. He describes his involvement with the Bone Marrow Transplant Program and the Masonic Cancer Center. He discusses the implications of the ALG litigation on the Medical School and the University of Minnesota. He also discusses the sale of the University Hospital to Fairview Health Systems. He concludes with the impact of changing imaging technologies on his field.

**Interview with Doctor Seymour H. Levitt**

**Interviewed by Dominique Tobbell, Oral Historian**

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

**Interviewed in the Department of Therapeutic Radiology Library University of Minnesota, Minneapolis, Minnesota**

**Interviewed on April 4, 2012**

Seymour Levitt - SL
Dominique Tobbell - DT
Emily Hagens - EH

DT: This is Dominique Tobbell. I'm here with Doctor Seymour Levitt and Emily Hagens. We are interviewing Doctor Levitt in the library of the Department of Therapeutic Radiology. It's April 4, 2012.

Thank you, Doctor Levitt.

SL: You're welcome.

DT: To get us started, can you tell me a little bit about where you were born and raised and your education?

SL: Yes. Actually, I was born in Chicago [Illinois], but I was raised in Denver, Colorado. We left Chicago when…I think I was a year old or something like that. I was raised in Denver, and I went to school in Denver, and I went to the University of Colorado and the University of Colorado Medical School and graduated from there in 1954.

DT: What led you to pursue a career in medicine?

SL: I can't answer that question. I don't know. I always thought I was going to be a physician or wanted to be a physician. I can't remember when I didn't want to be a doctor.

DT: Did you have any family members who were physicians?

SL: No. No, not anybody.

DT: What was your experience like at medical school?

SL: Well, medical school is difficult, but I had a good time. We relaxed on weekends, usually. But it was hard. It was difficult. It was hard work, but I enjoyed it very much. Medical school is tough. It's not easy to get through. I think now with the selection process, they're not losing as many students as they did at one time. I think, for the most part, most of our class got through without any problem.

DT: When you graduated, am I correct that you went into the military service after that?

SL: No. I went into an internship first. I interned at Philadelphia General [Hospital]. I had a residency in internal medicine at the University of California-San Francisco.

At that time, there was a program called the [Doctor Frank B.] Berry Plan, which probably some of the other people you've interviewed mentioned. It was a matter of getting into the service. They didn't want you to come in and start a residency and leave after six months or a year or whatever. So I was advised by the people at San Francisco to try to get into the service, which I did. I was fortunate to be able to get in. I spent two years in the service.

DT: Where were you based when you were in the service?

SL: I was based in Germany, actually. At that time, we had a lot of Army there, a lot of Air Force, a lot of everything there.

DT: Were you, basically, taking care of the soldiers?

SL: Yes, mostly, but we had a clinic where dependents were taken care of also. I was attached to an infantry regiment, so we spent time out in the field in addition.

DT: That must have been an interesting experience.

SL: Yes, it was. It really was. I, at one time, thought of staying in the military, because I liked it. I found it very interesting and attractive, but some colleagues advised me, some of the people who were long-term military people suggested that it probably wasn't such a good idea to stay in the service at that time. So I got out, came out.

DT: Do you feel that your experiences when you were out in the field gave you a different perspective on medicine?

SL: Well, when you're in a clinic, it's different. It's sort of like a general family practice sort of thing. When we were out in the field, of course, it was different. That was a military situation. But, I liked it. I enjoyed it very much.

DT: When you returned to San Francisco to begin your residency in internal medicine, you did a second residency in radiology?

SL: In radiology, yes.

DT: So what led you to pursue radiology?

SL: I decided that I didn't want to spend the rest of my life doing internal medicine. I enjoyed the clinics and all that, but I wanted to do something different. Actually, at that time, I looked at possibly dermatology or psychiatry. But I thought that radiology would give me a good basis for whatever I wanted to do in the future. When I was in the radiology residency, part of that residency was training in radiation oncology, which I immediately really enjoyed. I didn't know anything about it. Mostly youngsters, even today, don't know much about radiation oncology. Obviously, in medical school, I didn't have it, wasn't really exposed to it. I really enjoyed it, liked it when I was going through my residency.

DT: What was the status of radiation oncology then in the early 1960s? What were some of the developments in the science and technology of radiation therapy?

SL: It was a developing field, really. Most of the radiation therapy programs were part of the department of radiology. At that time, everybody was essentially trained in radiation therapy as part of their program. There were some programs in just radiation therapy or just diagnostic radiology, but it wasn't very common for people to do that or to take that. Actually, most of the people of my vintage in radiation oncology were people that developed the field, in essence, so that it became, now, a separate specialty. At the time, there were very few people who were doing just radiation oncology. Almost all the treatments, et cetera, all the work was done as part of a department of radiology. It was only later that we were able to separate the two fields. So, now, the training is entirely separate. As a matter of fact, my board certification is in general radiology, which doesn't exist anymore.

DT: Is it designated diagnostic radiology now and, then, therapeutic…?

SL: Yes, or radiation oncology. Yes. But, at the time, we were trained not only in diagnostic radiology but radiation oncology and nuclear medicine. So we did all of that. Of course, all of those are now separate.

DT: Nuclear medicine, is that mostly magnetic resonance imaging [MRI]?

SL: No. Nuclear medicine is the use of isotopes for diagnosis and treatment, for example, for hyperthyroid conditions, thyroid, that sort of thing.

DT: As you say, those three areas have expanded significantly since then…

SL: They've really gone in different directions. I mean, they've gone in separate directions.

DT: At that point in the early 1960s then, as you say, radiation oncology was in its early stages, and primarily cancer treatment was either surgical or chemotherapeutic?

SL: No, no. We were treating patients at that time. We were treating quite a few patients. Radiation therapy has always been a part of the treatment of cancer, even from the days of discovery. Even from the early part of the twentieth century, they were using radiation therapy or treatment. It wasn't terribly sophisticated, but it was used. Almost from the time that they discovered the X-rays, they were using that for treatment.

DT: I actually have a student who is working on the history of radium therapy in cancer treatment for the early twentieth century.

SL: It goes back to the time of the [Wilhelm Konrad] Roentgen. I think the first patient was treated maybe in 1898. X-rays were discovered in 1896, if I'm not mistaken.

DT: After you finished your residency then in radiology, you held various positions as a radiotherapist?

SL: Yes. When I finished my training, I was able to extend my training in radiology so that I spent more time in radiation oncology. I spent a whole year, which was unusual at that time—later the training programs were three years—which was unusual, because most people then had six months. The University of California Department of Radiology was unique because it did have a very strong program in radiation oncology. Most of our people spent a year, six to nine months, whatever, and I was able to extend it another year.

Then, I went to Ann Arbor, the University of Michigan, and I spent a year with Doctor [Isadore] Lampe, who was a very well known oncologist at the University of Michigan.

Then, I spent another year in [the University of] Rochester, New York, in their department of radiation oncology with [Doctor] Philip Rubin, who had set up the department as a separate department at the University of Rochester Medical School. Then, I left there after a year.

I went to the University of Oklahoma in Oklahoma City and spent three years there. I was the head of the department. It was a separate department at that time.

Then, I went from there to Richmond, Virginia, for four years, again as head of the division…department. Actually it wasn't a department. It was a division. Separate departments really started in the late 1960s and early 1970s.

After four years there, I was recruited by the University of Minnesota and I've been here ever since. One of the conditions that I had for coming here was that they set up a separate department, which they did. At that time, before I came, it was part of the Department of Radiology. It was a section for the Department of Radiology. This Department has a distinguished history. I wanted a separate department and they were able to do that for me.

DT: I can imagine why one would want a separate department, but I wonder if you could elaborate. What were some of the constraints that the field faced if you were a division within radiology versus your own department?

SL: Well, you set the policies. It's quite simple. You're in charge. You report directly to the dean rather than reporting to a department head. You have priorities that might be different from the department of radiology, so what your priorities and needs are are frequently… Now, of course, they're completely different. I'm talking about equipment, personnel, et cetera. You've got to understand when I came here in 1970, there was very little as far as—well, they had good equipment; they had been good about getting equipment—building up the program. There were very few people here. There wasn't any radiation biology or, if there was, it was really quite elemental. So I was able to do that. I was able to build up the department, essentially. I had one staff person here when I came, somebody I had recruited from Richmond. One of my residents came with me who had finished his training program.

DT: What was his name?

SL: Tom Jones was his name, believe it or not.

DT: When you were building the Department, what were your priorities then? You mentioned radiobiology.

SL: We needed to increase, strengthen radiation physics and radiation biology and the oncology program, too. We needed to set up a program for training residents only in radiation therapy. At that time, there was pressure. At that time I was on the American Board of Radiology, which was in the process of separating, actually. During the time of my tenure on that board, they did actually separate into two separate specialties. That's what we needed to do. We needed to train people in radiation therapy. As I told you earlier, we were talking about people taking six months or nine months of training and, now, we're talking about three years and, now, it's even longer. It's four years of training. That's what we had to establish, we had to develop. We had to bring in radiology biology, and we had to set up a separate physics section, which we did.

DT: Radiobiology, is that really where a lot of the basic research takes place?

SL: Yes, it is. It's basic research, and it's basic radiation biology. It's what are the effects of radiation. How does radiation affect tissue? How does it act, essentially?

DT: The radiobiologists, were they physicians or where they sometimes Ph.D.s?

SL: They were usually Ph.D.s, yes. The one I brought here is still here, Doctor [Chang W.] Song. He had worked with me in Richmond. We were interested in the vascular effects of radiation. So, early on, we worked together in the research, but, as time goes on, it's very hard to run a clinical program and then, also, be involved in a laboratory. There's just not enough time, particularly if you're building a department, which is what I was doing.

DT: This is in the midst of the Cold War and fears of nuclear disaster, nuclear war. I'm wondering if there was a particular amount of funding available for radiobiology because it seems that there would be…

SL: Yes, there was money available. That's not really where we were going anyway. But there was a lot of research in that. There's been a lot of research. I think that did strengthen the amount of money that was available for research in radiation effects. But radiation biology is, essentially, radiation effects, whether it's treating a local area or whether it's a whole body, whatever.

DT: How about the medical physicists? Those are people who were trained originally in physics, who, then, specialize within medical physics?

SL: Yes, essentially. We have a residency program here now that was established while I was department head. So what usually happens is they get a Ph.D. in physics and, then, spend a year, sometimes two years, in medical physics. It's quite different. What we were talking about, if you were talking about physics as applied to medical physics, we're talking about treatment planning and the use of computers for various and sundry things related to the radiation therapy.

DT: If you're doing radiation oncology—you have a patient—how is the labor divided between the medical physicists and the radiation oncologists? What is each responsible for?

SL: The physician is the person who makes a decision about where to treat, what to treat, how to treat, and works with the physicist, essentially. The physicist is helpful. For example, I might have a particular situation and I go to the physicist and I ask about what does he think. Should we treat with electrons? Should we treat with photons? Then, also the treatment planning… Let's say, the physician outlines the area that he wants to have treated and works with a physicist to best design a plan for how that area should be treated. We work as a team, essentially. It's teamwork. Particularly, nowadays, everything is so much more complicated than it used to be because of all the technology changes and all. But, essentially, that's how it works. You work as a team.

DT: In the 1960s and early 1970s, what were the main technologies that were available to you?

SL: If you want to talk about here at the University of Minnesota or you want to talk about going back all the way… We used cobalt at other institutions, but when I came here, we were using linear accelerators, which is, essentially, the state of the art as it is right now. It's essentially what people are using. There are different modifications. Over the past forty odd years, we've been using linear accelerators. There were a lot of things that went into it. For instance, when I started training, we didn't have what we called simulators in which the patient is placed on a diagnostic X-ray unit, which simulates the therapy unit. So you get the films and, then, you determine whether that is where you want to treat, and, then, you get new films if you're unhappy with those films. This is quite different. In the past, we would get the films on the treatment machine. All of this has changed so dramatically that it's really sometimes hard to believe all the changes. Right now, everything is digital. When we were training, we would get films, X-rays. The films would be developed, and we would compare the films. Let's say the patient is on the machine. You design a field and the patient is on the machine. They take a sheet of film and see whether they moved or if the field has moved or whatever. Now, everything is digital. When you're sitting at the treatment console, you can see the simulator film. You can see the area that you are treating in the patient, so you can move, you know, one or two millimeters if it has to be moved. It's like *Star Wars*, actually, in some ways.

DT: Did the University have a linear accelerator before you arrived?

SL: Yes. They had just purchased not only a linear accelerator but they also had a simulator. They had purchased a simulator. In 1970, there were not very many places that had linear accelerators or simulators, for that matter. The simulator I can remember seeing, one of the first ones, was when I was visiting [Thomas] Jefferson Medical College [Philadelphia, Pennsylvania]. That was 1966 or 1967. So they were just devising these things. We had one here when I came.

DT: Can you elaborate a bit on the difference in the science with cobalt therapy versus the linear accelerator? I don't quite understand that.

SL: The fields are sharper. The linear accelerator essentially produces photons. The cobalt produces gamma rays, which are very similar to photons, but they're somewhat different. With the linear accelerator, the fields are more precise. Cobalt has a little bit of a tendency to splay a little bit. This doesn't happen so much with the linear accelerator. All of these devices, gamma rays or photons, they diverge a bit. The critical thing in radiation is to treat the tumor as much as you can without damaging or minimizing the damage to normal tissue. So it's very important that the fields are precise, the area you're treating is as precise as possible. You want to avoid damage.

DT: Do linear accelerators take up a lot of space?

SL: Well, they do, but so did the cobalt machines. We had some other machines earlier on. One of them was called the Van de Graaff, and one of them was a resonant

transformer unit, and they were quite large machines. They took up a lot of space, and they produced X-rays. So the development of the linear accelerator was really quite beneficial. Most places had cobalt units. I'm trying to think back now. We had a cobalt unit that came in about 1958 while I was in my residency at the University of California. We were one of the first places to have cobalt. I'm not sure exactly of the time, but here at the University of Minnesota, they had the cobalt fairly early on.

DT: You mentioned that Thomas Jefferson Medical College had one of the…

SL: Simulators.

DT: …first simulators. I'm curious where the research that developed these new technologies… Was that primarily taking place in academic hospitals?

SL: Oh, yes, usually. Almost all of the clinical research was done in university hospitals; although, there were some private hospitals that did do only radiation therapy. There was the Swedish Hospital in Seattle [Washington] and there was the Penrose [Cancer Center] Institute in Colorado Springs [Colorado] and those were unique places where they had people who had been trained only in radiation oncology. Most of those people were early on people that immigrated to the United States. My mentor, Doctor [Franz J.] Buschke was in Germany and, then, he moved to Switzerland and, then, from Switzerland to the Swedish Hospital and, then, to the University of California.

DT: These foreign physicians that immigrated to the U.S., why were they particularly innovative, do you think, in this area?

SL: Because there was nobody really trained in radiation therapy in this country. Much of that came from Europe, from the French, the Gustave Roussy Institute in Paris. We just didn't train people in radiation therapy. We didn't have people who could train people in radiation therapy. It was all sort of by the seat of their pants, really. That was part of the problem. We had some people who essentially trained themselves, like Doctor Lampe at the University of Michigan. He was an American, but he was put in a radiation therapy division. He was trained at the University of Michigan and, then, the person who was his mentor, so to speak, left, moved to New York, and Doctor Lampe was put in charge of the radiation therapy. That gives you some idea of what the concept of radiation therapy was. What he did was he just was a superb clinician, and he taught himself, essentially, and he did a good job of it. He was actually very responsible for, I think… There were three people that he trained. One of them was Philip Rubin, whom I mentioned; the other was Malcolm Bagshaw, who was the chief at Stanford; and then myself. These are people who were general radiologists who went into radiation therapy. I was on my way, so I was there as sort of—I don't know what you'd call it—a graduate. I was junior staff at Michigan. You know, you'd learn a great deal from him.

DT: How was he teaching himself? Were there textbooks written by the European physicians about how to do radiation therapy?

SL: No. It wasn't until later on that there were textbooks in radiation therapy. Interestingly enough, there were some textbooks that came out of England. One of them was by a radiation oncologist whose name was Levitt, believe it or not, but was not related. They were very small books. They really were. There just wasn't a lot written about it. Well, the same thing is true of almost everything in medicine. There were textbooks of surgery, textbooks of medicine, but radiation oncology wasn't written about, at least in this country. Actually, one of the first textbooks that came out was written by a radiation oncologist in conjunction with a pathologist. It was about cancer pathology. In there, there was something about radiation therapy. You understand that in those days, surgery was considered the only thing that was reasonable for the treatment of cancer. If somebody had a metastasis or somebody had a reoccurrence and they couldn't cut anymore, couldn't take anymore of the body off, they would send them to radiation therapy. It was a difficult time. It's interesting because the youngsters we have now going through their training, even the staff, have no idea what it was like. You were dealing with surgeons who were in charge, and they did everything. They did everything, so it was a difficult time.

DT: That was one of the questions I was going to ask: what were, perhaps, the relationships between radiation oncologists and surgeons and the medical oncologists?

SL: You understand that medical oncology was developed even later than radiation oncology. That really was probably in the mid 1950s that people started doing medical oncology. Doctor B.J. Kennedy, who was here, one of my colleagues, was one of the first, at least in this area. You may have heard about him. We had disagreements, as you can well understand, about whether a patient should be treated one way or another. When I was in training in medical school, the only chemotherapy that was available that I knew of was nitrogen mustard. That was what they were using on patients with Hodgkin's disease and so forth. You know, in this country, we were way behind the Canadians. The Canadians had English-trained radiation therapists. Their schools were at [the University of] Manchester and the Royal Marsden [Hospital] in London. They were *way* ahead of us, way ahead of us. We were retarded.

DT: [chuckles] As radiation oncology grew in prominence, was there any resistance from the surgeons who previously had primary domain?

SL: Oh, my god, yes. Yes. I think radiation oncology and medical oncology are kind of new kids on the block, so to speak. We had a lot of battles with the surgeons. I did, and I think most of the people in radiation oncology did.

I'm amused because patients would come down; they'd be sent down by the surgeons to have treatment. They would mark the area they wanted treated. I had a colleague—I think it was at Memorial—who had a patient with a neck tumor. He marked some lines on the patient and sent him up to the surgeon. He said, "Cut along the dotted lines."

[chuckles]

SL: That was the sort of thing that was going on. Really. Yes, it was an interesting time. I think the surgeons here were pretty reasonable. I didn't run into that too much.

I had somebody, who was rather prominent in one of the departments, who sent a patient down for treatment. That was when I first came here. I didn't have a biopsy, and I was reluctant to treat a patient without a biopsy. He was very upset. He said, "Well, I'm going to send the patient someplace else." I said, "That's fine. You do what you want to do. I'm not going to treat the patient without a biopsy."

It sounds ridiculous, but this is really the sort of thing that had to be established, because they had patients that were just treated. We were really technicians in those days. All of that has, obviously, changed. Really, the situation here was not like that. At one time, they would call downstairs here, not here but where we were, and they wanted somebody to bring some radium up to the operating room. Well, we're not going to do that, not while I was here. By the time I came here, we had a change in staff and so forth. I had probably more arguments with B.J. than I did with anybody else, but, really, not a lot. I must say that the people here were very respectful of our integrity. I told you that one anecdote, because that was the only thing that ever happened where somebody was upset because I wouldn't treat somebody. That's okay.

DT: At some point, did biopsy become just standard protocol to help with diagnosis?

SL: Sometimes, you have to treat without a biopsy. Yes, it is, to answer your question. But sometimes, there are situations, for instance, where a patient has a metastasis. They've got, say, breast cancer, and they've got vertebral collapse. In that instance then, you know, by and large, that that probably should be treated. Although, I must say, I've had situations develop where I've had a patient with lung disease and, then, developed a lesion which I thought was unusual for that particular disease. We did get a biopsy, and it was another disease. So patients, just because they have cancer, doesn't mean they can't have something going along with it.

DT: As radiation oncology is developing, are nurses starting to specialize within radiology?

SL: You're talking about technicians. Yes, the technicians now are trained differently. They either start out in radiation oncology or nursing and, then, they take extra training. When I first started here, most of the technicians were registered nurses, were R.N.s, who had come over and were taking care of patients, were treating patients, and were taught how to turn the beam on and do things like that. At one time, these were either nurses or diagnostic radiology techs. I think in the past twenty-odd years, maybe thirty years, it's been only people that are trained in radiation oncology, technicians. The nurses are usually nurses that are familiar with oncology patients. We have the nurses in a clinic and they help with the patients and so forth. You don't have to be specially trained in radiation oncology to work in the clinic here. But they do not actually turn on machines and whatever. Those are specially trained people.

DT: I have like a hundred questions in my head. I'm not sure where to do next.

In the 1960s, for example, were there specific cancers that radiation oncology was treating in particular? When were changes made in terms of which cancers got which treatment first?

SL: When I was in training, we didn't treat prostate cancer, for example. Now, that's almost competitive…it is competitive with surgery. So that's one area.

Hodgkin's disease is another area, and that's an interesting area, because we've gone through various phases with that disease. When I started in medical school and we had patients who had Hodgkin's disease, it was hopeless, absolutely hopeless. There was nothing for it. Then, we got into treating large fields with radiation, because there were some papers that came out from, particularly, Princess Margaret [Hospital] in Toronto [Canada], and they were treating patients with what they called extended fields radiation therapy. The first concept of it was back in the 1930s coming out of a Swiss institution, which, then, the Canadians furthered. Actually, they had very good results. There was a woman oncologist, an outstanding person. Her name was Vera Peters. She was very prominent in developing the concept of not only Hodgkin's disease but also lumpectomy in breast cancer. Again, this was kind of foreign to us. We just weren't in the game, at that time.

DT: What were the modes by which, then, American radiation oncologists were learning from Canadians and the Europeans? Was it mostly conferences and journals?

SL: There were people here who were interested. They just didn't have the background. Then, we had people like Doctor [Juan] del Regato, who was at the Penrose Cancer Hospital and who had trained in Paris. There was my mentor, Buschke, who was trained in Germany and Switzerland. Those people set up training programs so that people were trained just in radiation oncology. One of the other things where there was a lot being done was that people in training would go to Paris. They would go to Stockholm [Sweden]. They would go to London or to Manchester. Those were places where Americans were getting trained. The NCI [National Cancer Institute] sponsored that sort of thing. Not a lot of people did that.

DT: When you first arrived here at Minnesota, what was the culture in the Medical School like?

SL: [pause] I must say that I was received well. We set up a separate department. I had no problems. I must tell you, however, that John Najarian and I had been residents together in San Francisco, so I knew John from there. I would say we were friends. I was, I think, well received. I didn't have any problem with anybody, including the people in the Gynecology Department. They had a new head there. There was no problem about calling down and asking for radium. I just said, "That's not going to happen." I must say, I had more problems elsewhere than I had here, but, again, people were changing and concepts were changing. I can remember… Well, let's not get into

that. Not here but in one of the other places, somebody said, "You're going to treat this patient." I said, "No, I'm not going to treat the patient." That was the sort of thing that we went through. If you were not firm and solid in what your decision was… It's not a matter of being difficult to get along with; it's a matter of, is there an indication for treating the patient or is there not? If there's not an indication, then that patient shouldn't be treated…not for psychological reasons. I've had somebody say, "Why don't you just take him into the room"—not here; it wasn't here—"and don't turn on the machine, just take him into the room, so that he'll feel better." First of all, it's not ethical. I think it's immoral. It's not fair to the patient. Anyway, that's another story. Just to give you an idea of how difficult it was to establish this field.

DT: It's hard to imagine a different specialty or different clinician being asked or just giving a placebo, and they won't know any better, that there's something about radiation oncology that you can somehow fool the patient into thinking they're getting something that they're not.

SL: Yes, but that's immoral.

DT: Yes.

SL: It's unethical. Other than that, it's okay.

[chuckles]

SL: You see, we had to develop that—the diagnostic radiologists. The general radiologists were sort of used to that sort of thing. I mean, they weren't trained. The surgeons were God. They asked them to do something, and they would do it. That didn't happen here. If I'm there, it's not happened with any of the people I've worked with, but I know that it happens. I know it happened one place where I was, and I was asked to do that, and I refused. Let's not get into that.

DT: [chuckles]

SL: If you're going to develop a field, you've got to be ethical and you've got to be moral. You just can't treat somebody for psychological reasons. I mean, there is damage. The X-rays can do damage; they can hurt. I must say, other than that one instance, I never had any conflicts with any of the people here. I think they were prepared when I came. I made it very clear how I was going to operate.

DT: Can you elaborate on why you ended up coming to Minnesota then? I realize getting to start the program yourself and the department yourself might be appealing, but were there other reasons that attracted you?

SL: Not the winters, that's for sure.

DT: [laughter]

SL: The reason that I came here, literally, was to have the challenge of setting up a department. I would not have come here if they hadn't set up… I didn't need to leave Richmond. You tear up a family. I don't know how often you've moved, if you've moved a lot, but it's tough. If you've got children, it isn't easy, and particularly young kids, and girls, in particular, have a hard time. Girls are bad.

DT: [chuckles]

SL: They really are tough on each other if you're not part of the clique. Boys get along okay and if they're athletes, no problem. But the girls have a hard time moving. I have two girls and a boy. The girls had a tough time. If you move around a lot, it's not good, and we moved around a lot.

DT: When you came to Minnesota, it seemed an exciting time to be at the Medical School, because the surgeons had spent two decades doing pioneering heart surgeries and…

SL: Oh, yes, it was great. This was one of the outstanding medical schools. When I came here, it was really one of the top medical schools in the country, really, really. [Christiaan] Barnard, not only he but [Richard] Varco, [C. Walton] Lillehei … It was an incredible place. If you'd look at all of the departments, everything in Pathology, Biochemistry, Physics, Physiology, people were writing books here. This was one of the really, really top schools in the world, not just in the country.

DT: There was a lot, it seems, going on with cancer treatment and research with Bob [Robert] Good being here.

SL: Bob Good had left by the time I came here, but he had established a program. Then, I said B.J. Kennedy, so, you know, we had some very prominent people in the field. I'm trying to think of the guy who was here in OB-GYN [Obstetrics and Gynecology]. I can't remember his name. He went to Northwestern to be head of the department down there. I cannot for the life of me remember his name.

DT: I can probably find it out.

SL: I was here about four years and he left. Then, Konnie [Konrad] Prem took over the department. He was very easy to work with and very good. It was an exciting time to be here.

DT: The bone marrow transplantation program had just been…

SL: Yes, we were very much involved in developing the bone marrow program, working with the people that were there, John Kersey and—my memory is slipping a bit—Mark Nesbitt, Norma Ramsey, people like that. I can't remember all the names. I'm getting a little long in the tooth.

DT: [laughter]

Can you talk more about what your role was in setting up the bone marrow program?

SL: Well, I worked with the group that was doing the bone marrow… We set up the protocols. We set up techniques. Actually, one of the things that we did was use linear…because at one time cobalt was what was used for bone marrow transplant radiation. We set up the technique using the linear accelerator. As a matter of fact, it was one of the key things that we did, because the dose rate with the linear accelerator was quite different from that of the cobalt. The dose rate may have been important or may not have been important, so we had to determine that with animal experiments. That was one of the things we did. We set up the protocols. When I came here, I was involved. Doctor [Tae] Kim, who was one of my residents, then took over working with the bone marrow transplant people. Katie [Kathryn E.] Dusenbery is now working with them. Kim left and went to Abbott and is now retired, playing golf, and here I am.

[laughter]

DT: The University was designated as a Radiation Cancer Research Center in 1975. Can you talk about what led to that?

SL: I think we had a training grant, at that time. We were just getting everybody together in the group. We had a very strong group, at that time. We had Faiz Khan, who was the head of Radiation Physics, a world-renowned physicist. We had Doctor Song, a radiation biologist, again world-renowned. So we had a very strong program. We had the bone marrow transplant group that was here. These people were, or are, very well known, not just here at Minnesota but, obviously, everywhere. They're internationally known, international figures.

DT: How did that designation impact the department? Did that mean more funding?

SL: Yes, more funding. We had more funding and we had a training program that paid for residents. It also helped finance research. It was important in the development of the program, the department.

DT: You mentioned earlier about when radiation oncology became its own specialty and residencies. Do you remember when that was?

SL: It was in the 1970s. I think 1974 was when they set up the separate specialty training and certification, which was important. I'm not sure of the exact date, but I think it's somewhere in the early 1970s.

DT: I can look that up.

SL: I think 1974. You know, that's a few years ago, I want you to understand.

[chuckles]

DT: That's just a couple of years.

SL: For you, it's ancient history. Dates like that, precisely…I can tell you when my birthday is, but I can't remember a lot of those dates.

DT: That's okay. Emily and I can double check on dates when we need to.

SL: Yes. Right.

DT: As I understand it, there were efforts at the University to set up a cancer center in the 1970s.

SL: Right.

DT: Can you talk somewhat about that?

SL: Sure. We just had a problem. You've got to understand we had some very strong egos here. I know it's a problem getting the egos to work together—not me.

DT: [chuckles]

SL: No, seriously. I was not involved in it. I didn't care, but B.J.…there was conflict between him and one of the surgeons, the surgeon who was a surgical oncologist.

DT: What was his name?

SL: Charlie…

DT: Charlie McKhann?

SL: Yes, Charlie McKhann. I don't want to cast… It was a difference of opinion on how to develop it. You had some strong egos, so it created problems in getting everybody together.

DT: That makes sense. In the material that Emily and I have seen, that plan was opposed by Kennedy and some of the other faculty, but McKhann was particularly pushing for it.

SL: Pushing it, yes.

DT: Yes.

SL: I say we had some strong egos…good people, but they had strong egos. I will say that we were cooperative. I don't think we had a problem with the plans. There was

nothing in there that was upsetting to me, but whatever. The two other people just clashed.

DT: Then there were renewed efforts to establish the [Masonic] Cancer Center in the 1980s.

SL: Yes.

DT: You took quite a lead role.

SL: I was involved in that. We had a committee that was co-chaired by John Kersey and myself. We set up the Cancer Center. Actually, I was the chairman of the committee that chose the Cancer Center director, and that was John Kersey. After that, I wasn't terribly involved in the Cancer Center program.

DT: Where did the impetus come then for these renewed efforts to establish a cancer center? Why late in the 1980s did you pursue this?

SL: Well, we should have a cancer center or we should have had a comprehensive cancer center. We should have had one early on. We had people, B.J. and Charlie McKhann, and the bone marrow group. We had plenty of people here who were very strong. We should have had it. There was no reason…just because of the clash of the two principals, the surgeon and the medical oncologist. It was ridiculous that this institution would not have a comprehensive cancer center. We, also, had Mayo [Clinic, Rochester, Minnesota], who was a cancer center. You know, it's sort of a slap in the face—not that Mayo got it but that we didn't, because we couldn't get our act together. I think when Charlie McKhann left and B.J. cut back a bit, then we set up… I can't remember who the dean was at the time that wanted us…

DT: Was it David Brown?

SL: It could have been David, yes. Yes, David suggested that we go ahead. This place had gone through a bit of turmoil. Shelley Chou… I can't remember all the details, but David resigned, retired, and Shelley took over for a while. He really pushed this. I think it was when he was dean that we named John Kersey as the director.

DT: What was the attitude among the rest of the faculty at the University and the University Administration?

SL: About the Cancer Center?

DT: Yes.

SL: Oh, I think they were supportive of it, as far I know. The thing is that if you're talking about Central Administration, they don't know what the hell is going on here. They just have no idea, and I think that's not good. That's really bad. We had, I think,

malignant neglect. So it's not been good for the school. I think it has created problems for us.

DT: I think, at the time, it was Neal Vanselow who was senior vice president.

SL: Yes. He left. All of this commotion started with [John] Najarian, the [Antilymphocyte Globulin - ALG] thing with Najarian. You'll get different opinions from people, but I think the whole thing with Najarian was ridiculous. It was absolutely a disgrace, *not* what Najarian did but what the Board of Regents and the President of the University [Nils Hasselmo] at that time did. He was a disgrace. There were things people said like they didn't know that the building belonged to the University. I mean, they built a building, and the University Board of Regents didn't know the building was there? I think it was President Hasselmo who really, really created problems for the Medical School. He was absolutely terrible, as far as the Medical School was concerned. I don't know how much of this you're going to repeat, but I don't care. I think he was terrible.

And I think [William] Brody, who came here to replace Neal Vanselow was an opportunist who came here and felt that we were an inferior school. So he sold the Hospital, and Hasselmo went along with it. He sold the Hospital to Fairview [Health System], which I think was an absolute disaster for this institution. I don't care; I'll be very honest. I think that was a disaster, and I think Doctor [Frank] Cerra did not help this institution with the stuff that he did. He completed the sale to Fairview. They kept saying that we had to do this. We had to do this. We didn't have to do it. It's created problems for a lot of the departments, because when the University Hospital was the University Hospital, they were extremely helpful. They supported staff. They were able to do that, because we were all one unit. So, now, with Fairview coming in, well, no, they can't do that. It's illegal. It's created problems. I think Hasselmo, Brody, and Cerra are responsible for a lot of the problems that the school has.

We are number thirty-nine now, they say. I'm not impressed at thirty-nine. That's nonsense. Thirty-nine? Do you feel good about thirty-nine out of 110 medical schools, when we were in the top five? Ahhh…

DT: Focusing on the Najarian case with the ALG, why do you think Hasselmo took the path he did with Najarian?

SL: I can only hypothesize.

I'll give you an example of something different. Bernie [Bernard] Fisher, who was at the University of Pittsburgh, was the head of the NSAB…I can't remember all the initials [NSABP, National Surgical Adjuvant Breast and Bowel Project]. He was head of that, and he got accused of something similar. One of the institutions reported results that were not reliable or whatever, and he got attacked for that. They were going to kick him out, and he sued.

So Hasselmo is lucky because Najarian didn't want to sue the institution—and he should have. He should have. He and his family went through hell for nothing. As you know, they threw the case out of court. It was a disgrace to the University. It was disgraceful. I know John Najarian. I wouldn't say I'm a close friend, but I consider him a friend. He did a tremendous amount for this institution. All that money from the ALG was being turned back to the University, for God's sake. Part of the thing that happened was that the FDA [Food and Drug Administration] didn't do anything and, then, they tried to cover their backsides by accusing him of doing something. This, again, is that the drug companies were upset because of the ALG, and it was competing with their places. It was very successful. It was a successful treatment. So they got the FDA to come in. Well, they were wrong and the school should have fought it. That's why I brought up the thing about Bernie Fisher. The school should have fought this and they didn't. I think it was because Hasselmo either was afraid or he was… I don't know; I have no idea. He should never have been president of the University of Minnesota. He was a disaster. He'll probably go down, if anybody checks it, as the worst president they've ever had at this institution. Other than that, I think he was great.

[laughter]

DT: The Najarian case had implications for the Medical School…

SL: Oh, absolutely.

DT: Can you say something about how the case affected the Medical School more generally?

SL: I think it demoralized people. I think it also divided the faculty. I probably shouldn't be talking so much.

I think there were people who were jealous of Najarian. There were people who were jealous of Najarian. John is a very strong person. He's a very strong figure. You probably won't get this out of him. He probably will never say a word. I don't know; maybe he would. He should, because I think he was badly treated. The faculty should have supported him, but they didn't. There was a lot of this: "If you knew what I knew…" "I don't know what you know." "So what are you talking about?" "Please, explain to me."

John had a problem with trusting people. He had this guy who was his administrative assistant, and he trusted him, and he made mistakes. I can't recall all of it. I really think it was that people didn't turn the reports in, whatever. The FDA didn't ask for reports for twenty years.

I've had to deal with them. We had a hypothermia machine here that we used for a number of years, experimenting with it. Nobody told you that you had to turn a report in. That's part of their job to say, "Where's your report?" Three years later, "Where's your report?" "Why didn't you report?" This is the sort of thing happens with them.

I think there were jealous people. There was some incompetence, and we had a president who didn't understand. [sigh]

We had Brody who thought this was a second grade institution, and he didn't understand. If he did understand, he didn't care. He was on a trip. He was going to go back to [Johns] Hopkins [University] to be the president there. Now, he's the head of the Scripps [Research] Institute. I heard—I don't know whether this is true or not—that he was told when he went back to Hopkins, "If you try to do anything like what you did to the University of Minnesota, you're going to be out of here." He kept away from their medical school and from their research institute.

Have you talked to Cherie Perlmutter?

DT: No. She's on my list. People tell me she may be reluctant to talk.

SL: Well, she may be. I don't know.

DT: But I definitely do want to sit down with her.

SL: If she wants to talk, she can probably tell you a lot more about what went on than I can. I don't know all of the stuff that went on with the Board of Regents, and the president's office, and Brody, and Frank Cerra. Frank Cerra followed through with Brody's plan.

You know what? After Hasselmo left, none of the presidents of the University have really looked into what's going on here, including [Mark G.] Yudof, who was supposed to be such a wonderful president. I understand there's a committee looking at the Medical School. Are you part of that committee?

DT: No, I wish. [laughter]

SL: Do you really wish?

DT: Well, no, I don't at all. I think it will be useful if they understandd the history of the institution. It's not a long history. That would be helpful for them to know. I really wouldn't be, as a junior faculty member, on the committee.

SL: Somebody needs to look at where this place has gone…to number thirty-nine and they're so happy about that? You've got to be *kidding* me. I'm embarrassed. The University of Colorado had very little when I was going to medical school there. They didn't have a lot of research going on. When you look at the history of this place, this was one of the top medical schools in the world, let alone the country. Now, we're number thirty-nine. Well, why is that? Because we've had lousy leadership in the president's office.

DT: Going back to the setting up of the Cancer Center in the 1980s, there was a lot going on at that time. Was there State Legislature support for the Cancer Center?

SL: I honestly don't know. I think most of the money for cancer centers comes out of the National Cancer Institute. I think there was some money put in which was donated by the Masons. They put some money in, but, basically, most of the money, I think, came from the National Cancer Institute. Once John [Kersey] was appointed as the chair and the committee was disbanded, I really didn't get involved in that. I wasn't on the committees that were looking at funding and stuff like that.

DT: How was that decision made about appointing John Kersey as director? It was a national search, as I understand it.

SL: We had a national search, and we had a selection committee. We had a committee of various department heads and people who were prominent in the cancer field. We interviewed people. As I recall, usually with something like this, you send two or three names to the dean and, then, the dean decides. Shelley Chou was the dean, at that time, and he was the one who made the decision. This is what you do with a selection committee: you narrow it down to two or three names and, then, you send them on to the dean. The dean is the one that finally makes the decision.

DT: I realize you said that once the Cancer Center was developed, you weren't really involved with it. Was there any way in which the establishment of the Cancer Center influenced what was going on in the Department of Therapeutic Radiation?

SL: Our department?

DT: Yes.

SL: No. Well, not really. No. We were involved. I was on the Cancer Center as a member of the Cancer Center, as was Doctor Song and Doctor Khan. Our staff was on it, but we were not really active in it. A lot of it was related to bone marrow transplants and, at that time, I wasn't working with it. Katie was working with that. No. When we selected John, that was the end of my active participation in the Cancer Center.

DT: During your tenure as head of the Department, how much was the Department doing in terms of clinical trials versus cancer treatment?

SL: We were involved in clinical trials. We were very involved in clinical trials.

One of the problems we ran into was there were a number of cancer groups, like the CALGB [Cancer and Leukemia Group B] and the GOG [Gynecologic Cancer Group] and all of these. One of problems that we had so far as getting into the Radiation Therapy Oncology Group was the fact that so many of our patients were going on a protocol for the other groups. So it was difficult to accrue a lot of patients. We were very involved with the other groups. I can't remember the groups that were there. You realize it's been

since 1999, and that's a long time. We contributed patients to those groups. There's the Pediatric Cancer Group and the Bone Marrow. We were working actively with the bone marrow transplant people. Yes, we were very much involved in clinical trials and we did a lot of research. We had a lot of research coming out of here in radiation biology. Doctor Song, if you look at his record, he's had multiple grants. He's very well recognized.

DT: In terms of conducting clinical trials, were there any particular ethical issues that kind of crop up with doing trials when there aren't necessarily established treatments available for patients and the best path is to get them in trials? Are there any kind of ethical issues that you feel shape that process?

SL: Most of that would relate to the bone marrow transplants. There was a lot of stuff that went on with that, because of the toxicity of the treatment and so forth and so on. If I'm answering your question correctly, I think most of that was related to the children's cancer groups. There was nothing, as I recall, that was really a serious problem. I'm not sure I'm answering your question.

DT: I don't know a lot about the kinds of trials that the department was doing. Bone marrow transplantation and certain chemotherapeutic…

SL: Yes, but that was different doses of radiation and different approaches of radiation, different areas that we were treating. As I said, we were working with these multi-institutional cancer groups that set up protocols, and we followed the program, worked with them on those sorts of things.

DT: [speaking to Emily Hagens] Do you have more questions on the Cancer Center?

EH: I don't think right now.

DT: When you arrived at the University, the health sciences had actually just undergone a reorganization.

SL: Yes.

DT: The College of Medical Sciences had been disbanded and reconstituted as the Academic Health Center. Did you get any sense for how that reorganization was affecting things at the University? Did it impact you, at all, or your department?

SL: Not really. Lyle French was the vice president for health sciences or whatever they called it at that time. They've changed the title a number of times. He was a very good leader, a very strong leader. I didn't feel affected by it. When I was coming, the dean was just leaving and they had a number of associate deans. No, I didn't really have any situation that I thought was a problem. Everything had been agreed to. They did what they said they were going to do.

DT: Neal Gault was the…

SL: Neal Gault came later. He was probably, in my estimation, the best dean that we had while I was active. He was a very good dean.

DT: What were his qualities that you think led him…?

SL: He listened to people. Have you heard that before?

DT: Yes.

SL: Yes, he listened to people. Some of the other deans—I won't name names—they would think for you, but Neal listened to people. He was very low key, a very nice person. He was a very *human* human being. He was a great guy. I was very fond of Neal.

DT: What were relations like with University Hospital when you arrived?

SL: Oh, they were *very* good. The Hospital, of course, was part of the group. It belonged to the University. I got along very well with the administrators. I knew the administrators, and I could talk to them, and I could present a budget to them. I have no idea what's going on now with the budget. At that time, I could talk to them. If we needed equipment, we talked about it. I understood where we were, and they understood where we were. It worked well, I thought. I don't know how it's working now. I have no idea, but I don't think it's working as well. You're part of a huge operation as opposed to a smaller one and a discreet unit as opposed to what you have with Fairview, because Fairview is humongous. The other problem with Fairview is they don't really understand radiation therapy, because they've never really had it. I think this is the only place where they're in charge of the radiation therapy, administrative charge.

DT: As I understand it, John Westerman was the Hospital director when you got here.

SL: Yes, John Westerman. Exactly.

DT: He started up a clinical chief's meeting when he would have Tuesday lunches with the clinical chiefs.

SL: Yes, exactly.

DT: What I've heard from the Hospital administrators I've spoken to… I'm going to interview John later this month.

SL: Are you flying down there to see him?

DT: Yes.

SL: That's a hell-of-a-deal.

DT: Yes.

[laughter]

DT: That's what I thought.

SL: How do you get a job like yours?

DT: I'm thankful for it everyday, especially every day I fly somewhere warm.

SL: You can't complain about the weather here this winter.

DT: No, no. It seems like almost a waste to fly to Florida in April.

SL: Yes, right. You should have done it in January.

DT: Yes.

I've heard from many people those lunchtime meetings were a good opportunity for the clinical chiefs.

SL: Oh, I would say it was great. I don't know if they're still doing that. They may have stopped it. It was very good. I think it was excellent. You met your colleagues there, and you discussed problems. It was very good, very good. I'm sorry that I don't know what happened. I think once Fairview took over or maybe even before… I have no idea what's going on since I left the chair.

DT: During the late 1970s, there were efforts to begin building a new hospital, expanding the hospital.

SL: Right.

DT: Do you have any perspective on that process?

SL: I think it was needed. The hospital was needed. I think John Westerman was extremely important in getting that thing going. You have no idea what this hospital was like before then. It was really antiquated. We had to fight. It was a political fight about getting the hospital, because nobody wanted us to have a hospital like this. It was a good thing, absolutely. I don't know what other people have told you, but, as far as I'm concerned, it was a good thing.

DT: In most comments I've heard, the State Legislature was resistant to giving money to build the hospital, and there was some just general reluctance outside the Medical School for the hospital.

SL: Well, you've got to understand there was a lot of lobbying going on. Nobody wanted us to have a state-of-the-art hospital. They didn't want it, our colleagues in the community. I can tell you things like we were criticized for not having joined an HMO [Health Maintenance Organization]. The HMOs didn't want us. I was at a meeting with the County Medical Society who were running an HMO. We said we wanted to join. They didn't want us. We tried. There's been this very terrible town/gown problem here, probably as bad as I've ever seen the town/gown problem. They didn't think we needed it. I don't know what their thoughts were, but we couldn't have survived without the new hospital.

DT: Why didn't the county medical society want the Medical School in the HMO? Were they worried about competition?

SL: Yes. Now, it's sort of interesting, because one of the things that Brody tried to do is he—I know this—tried to get Mayo to come up and take over the hospital. They didn't want to do it and the reason they didn't want to do it was because… I talked to one of the people who is from Mayo whom I know, and he said, "Well, we were afraid about our referrals from Minneapolis." Now, they've got a clinic they're building at the Mega Mall [Mall of America, Bloomington, Minnesota]. Come on. This is all cut and dried competition. That's what it is. It's unfortunate.

DT: I'm glad that you brought up the town/gown, because I was going to ask you about that. I'm really interested, given that you've worked in so many different places, that you think it's been particularly problematic here.

SL: You have to understand that my position here is quite different than any place I've ever been, so I have no idea… If you'd ask me what's going on at the University of Michigan at Ann Arbor with the local hospital, I don't know. I never was in that kind of position. I am in a position, or was in a position, now that I can sense it, or I was involved in what was going on.

DT: Was there anything beyond competition that the community physicians were complaining about?

SL: I heard, but I don't know, personally. Some of the surgeons in some of the other hospitals got into fights with Doctor [Owen] Wangensteen, who was the head of the department before Najarian. He was a tough cookie. There is some personal animosity that goes on. A lot of it is historical. I don't think it was…maybe it was John. I don't know. A lot of it is surgeons. I think more of it was with the surgical unit.

DT: In the 1960s and 1970s, there were real concerns about shortages in the health workforce, not just physicians but nurses and dentists, in particular concerns about rural practice. I thought I'd seen somewhere that you or the department was somewhat involved in trying to get therapeutic radiology in some of the affiliated hospitals or getting patient access outstate?

SL: Yes, we'd been trying for years. We were trying for years to try and get into some of these other places and they didn't want us. Methodist Hospital was setting up their radiation therapy, and they decided they didn't want the University in there. So that's been part of it. We did have a program with United [Hospital] for some time, but, now, that's been taken over by Minnesota Oncology. I can tell you things not for the record. There's a lot of stuff that goes on. There's a lot of jealousy. There's a lot of cutthroat competition.

DT: This may seem like a silly question, but do you think that ultimately patients are affected by that competition?

SL: If you think that this place provides the best possible treatment for patients, then, yes, you might say that by affecting us, the patients may be harmed. But, on the other hand, you have to understand, the quality of medical practice in this community is very high. We have some really outstanding physicians in the community and we've got Mayo that's not very far away. Now, that they're in the Mega Mall, I wouldn't be a bit surprised if they start doing some other things, maybe even building a small hospital or building a radiation therapy center. I don't know. I was quite surprised about them going into the Mega Mall and setting up shop there, particularly since they don't want to offend the local doctors. That was their reason. I can't wait until the next time I meet this guy and ask him what happened.

DT: [chuckles] I guess the health economy suddenly changed.

SL: Yes, well, I think that's part of it.

DT: I remember one of the questions I wanted to ask about the hospital that I forgot a few moments ago. The Board of Governors was established in 1974 for the Hospital as a new governance…

SL: Yes. John Westerman was very much involved in that.

DT: Did that seem to create any changes at the Hospital that you were aware of?

SL: I think it was good. Personally, I think it was good. I don't know what some of the other people will tell you. I think it got the community involved in knowing what was going on at the Hospital.

[break in the interview]

SL: It was very good. The only problem they had was that some of the people on the board did not understand what a teaching hospital was. That is where there was an impetus to sell the hospital, because we were not operating efficiently. We didn't have people who were businessmen, so to speak. Well, that was not true. They had no concept of what a teaching… That was a problem. That really created a problem for us.

I think those people should have been educated. You see, I think that's part of the problem with Fairview. They have no concept of what a teaching hospital is or what you have to do, and they don't want to pay for it. They don't want to pay for it. That's not good; that's not good. That's why we're number thirty-nine.

DT: What do you see as the primary responsibility of a teaching hospital, and how does that contrast to the non-teaching hospitals?

SL: First of all, the expenses of a teaching hospital are going to be higher per patient than they are in an outside hospital, because you've got medical students. You've got residents. You've got staff. It can be controlled. It's going to cost more to have a patient here in this hospital unless you get rid of the teaching. If you've got residents going through, unless you give them opportunity to order things or make decisions or do things, they can't learn. They don't learn. This is, essentially, what the problem is, as I see it. Fairview is a for-profit, not for profit organization. I can't blame them. They never should have been sold this hospital. This hospital never should have been not a teaching hospital. If you go to any other hospital, you don't see residents. You don't see nurses in training. You don't see medical students. It's quite a different atmosphere. As such, they need to take those things into consideration. In all fairness to Fairview, that's not their job. That's not what they're in this for.

DT: I imagine with a teaching hospital, too, there's more constraint on how many patients you can have, because you don't want to have too many patients so that compromises the teaching.

SL: You need to be careful about the number of patients that you have. That's not what Fairview is in business for, in fairness to them.

DT: Two quite different cultures.

SL: Exactly. Absolutely. It's not just teaching. It's research that's going on in the hospital. When we had the University Hospital, they would help with staffing here, would help support staff. That's not happening.

I think you'll get a better answer out of John Westerman. By the way, give him my regards.

DT: I will. I've already had several phone conversations with him so I'm really looking forward to chatting with him.

SL: He's a very bright guy, a very bright guy. I was very fond of John. I thought he did a nice job. We were, I would say, good friends.

DT: I just have a couple more questions.

SL: Yes. I'm going to have to leave in about a half hour.

DT: Yes.

One of the things that I'm curious about… I know you talked at the very beginning of our interview about the differences between diagnostic radiology and therapeutic radiology. Obviously, within diagnostic radiology, there's been new imaging technologies that have been introduced in the last thirty, forty years.

SL: Yes.

DT: I'm wondering if the arrival of new imaging technologies impacts…

SL: Of course, absolutely.

DT: Can you elaborate?

SL: Just take PET-CT [positron emission tomography-computed tomography], so we have some idea. One of my colleagues said he would never treat a lung cancer patient without them having a PET-CT beforehand. That's the sort of thing…that's how it has affected us. PET-CT is one of them. MRI [magnetic resonance imaging] is another. That's had a real impact for defining the tumor. Now, our diagnostic people can really determine, let's say, prostate tumors, where the tumor is outside the prostate or still inside. This has how sophisticated some of these things have become. Breast mammography. If you want to talk about what has changed since I was in training, it's a lot. Like I say, the PET-CT, MR, that's all brand new, even CT is new, image amplification. All of these things have had a significant impact on diagnostic and therapeutic radiology, radiation therapy. Yes, that's made some really significant changes.

I wrote an editorial with a colleague once about the need for us to get together more significantly with our diagnostic colleagues, because of the importance of the imaging. I can tell you at the Cancer Center at the University of Pennsylvania, they have people that are assigned to work with the oncologists from the imaging department. That's good. That's really good.

As you know or may not know, the residents rotate through the various services but the staff is pretty well specialized to certain areas.

DT: Has there been much interaction among radiation oncologists here or just more generally among radiologists with the companies that are developing these new imaging technologies?

SL: Imaging? No. I think we've had a lot of interaction with the people that are developing new machinery, new equipment but not with the imaging people so much.

DT: What about with the manufacturers then? Are the radiologists being asked to input how these machines should be developed?

SL: Well, not me.

DT: [chuckles]

SL: Some have been, of course. I think that's had a significant influence. Most of these companies have a scientific advisory board that advises them on what is needed or what developments they should look into. I, personally, have not been involved in that.

DT: I assume that the department has gotten a good amount of funding over its lifetime from the National Cancer Institute.

SL: I don't think that right now we have any funding from the National Cancer Institute, unless there's some money coming in from the Cancer Center, which I don't think is true. I think the department pretty much supports itself—or has to support itself.

DT: So that's mostly with the clinical services then?

SL: Yes, exactly, and that's created problems for us.

DT: How so?

SL: Well, we don't have the amount of money coming in to do, for instance, radiation biology. There's no money for research, so these people now have to depend on grants. When I was in charge, of course, we had more funding at that point, and I was able to support research in radiation biology and things of that nature. The department doesn't have the funding.

DT: Is it a decline in federal and other kinds of funding overall or is it less interest in radiation biology?

SL: I think everybody's cutting back. The state has cut our funding in this Medical School so much that it's almost ridiculous. I think that's had an impact. There aren't the state funds for supporting the departments, and that creates havoc.

DT: We've covered a lot of ground. I wonder if there's anything else that you want to share about the institution's history.

SL: I've told you how I feel. I think I've made it very clear about how I feel about being number thirty-nine. I just think it's a disgrace. I'm hoping that the new whatever that investigative committee is will come up with something positive. I'm not sure. In all fairness to the institution, we're not getting the money from the state. If you don't have funding, it's very difficult. The state, since I've come here, their contribution has really dropped from when I came here in 1970. I'm not just talking about the Medical School;

I'm talking about the whole University. I think that creates problems. I think we're just not getting funded. I think we're not unique. I think other universities are having problems. Then, you know, if you raise the tuition, the kids have problems. They come out of here in debt up to their eyeballs. That's very worrisome and, of course, not just for medical school but you've got youngsters coming out of law school who can't find jobs after God knows how much money they're in debt. These are very difficult situations. I feel sorry for these youngsters. I don't know what the tuition is here now, but when I was in medical school, it was $500 a year.

DT: It's about $33,000 in-state and $36,000 outstate.

SL: It's $50,000 or something like that. That's pretty standard, yes. I think that's a very big concern. Anyway, don't get me started on politics.

[chuckles]

DT: Thank you so much.

SL: You're welcome. I hope you'll see Cherie and talk to her. She's a fantastic source and resource. She knows where all the skeletons are hidden, but she may not tell you where they're all hidden.

DT: I know. I get that from everyone. I want to be as well prepared as possible, so I can convince her to talk to me.

SL: I have nothing to lose. The only thing they can do is fire me as an emeritus professor, which—I'm not sure—they might do it any day anyway. I hope whatever we've done today will be helpful. I'm very concerned, as I've mentioned before. I just can't believe that people are comfortable with us being number thirty-nine. You know, it's like your football team, which is pretty bad now.

[chuckles]

SL: It's sort of sad. It's really hard to see this place…having been here in 1970 and seeing what's going on now is just really sad.

Anyway, good luck.

DT: Thank you.

[End of the Interview]

Transcribed by Beverly Hermes
**H**ermes Transcribing & Research Service
12617 Fairgreen Avenue, St. Paul, Minnesota, 55124
952-953-0730 bhermes1@aol.com