Interview with John Westerman

Interviewed by Associate Dean Ann M. Pflaum
University of Minnesota

Interviewed on May 24, 1998

John Westerman - JW
Ann Pflaum - AP

AP: Today is May 24, 1998. This is Ann Pflaum with John Westerman. John, would you give me your address? One of the things I need to do is send you a permission slip for the interview for the human subjects.

JW: Certainly. My address is 24410 Marsh Landing Parkway, Ponte Vedra Beach, Florida, 32082-2133.

AP: What this interview is about, John, is that the university has commissioned a history that's going to cover the last fifty years. We're talking to different parts of the university. I talked to Lyle French and Cherie Perlmutter. Paul Quie is on our advisory committee. I've talked to the different deans in the different schools and, obviously, the Hospitals is a big piece of this history. Could you give me a little background—we're asking people to do that—on where you went to college, what you majored in, how you arrived at the university?

JW: Sure. I went to the University of Minnesota. I'm a Minneapolis native. I had a bachelor of science of law. I was in Law School for two years and, then, got called into flight school. I was an ROTC [Reserve Officers Training Corps] student. Then, I came back. I had taken some additional courses so I got a bachelor of business administration with a major in finance in 1958. The first degree, I think, was 1954. Then, in 1960, I got a degree in health administration from the University of Minnesota. I came to the University Hospitals as an administrative resident under Mr. [Ray] Amberg in 1959 and was there 1959 to 1961. Then, I went to the University of Rochester in upstate New York for three years. When I came back, I worked in Dean [Robert] Howard's offices to start with, the dean of the College of Medical Sciences then, and, then, I went to President [O. Meredith] Wilson's office as the project grew larger and was executive secretary, I think, for the Health Sciences Planning effort from 1964 to 1966. Then, in November 1966, I took over as general director of University Hospitals and Clinics.

AP: Remind me who you followed as general director.

JW: Mr. Amberg retired—let me see if I can get this straight—in about 1964 and Gertrude Gilman, his long-time associate, served as the director from, I believe it was, 1964 to 1966.

AP: Would Gilman be spelled G-i-l-m-a-n?

JW: Correct. She was going to take a long awaited boat trip to Asia. She was diagnosed with cancer. That's why I was the designate in April 1966. She went into the hospital in mid November and I believe she died the next spring.

AP: So, she died in 1967. That must have been unusual to have had a female hospital administrator in those days?

JW: Not as unusual as people today think. I can think of several others. Elizabeth Behang was the director at the University of Pennsylvania. It was unusual, yes, but . . .

AP: How do you spell her name?

JW: I think it was B-e-h-a-n-g. That's from memory. I don't know that I would have that record. I had thought the same thing and often talked to Miss Gilman about that. In fact, we were one of the first in our administration at Minnesota to start a program for minorities who could come with us a year before they went to Graduate School. We included in minorities, in addition to blacks or African-Americans—I'm not sure of the politically correct term today—women. There are a number of women that worked with us for a year and, then, they went into Graduate School.

AP: Hospital administration must have been an emerging field after the Second World War or was it a fully regularized field before?

JW: You're essentially correct. The first program was at the University of Chicago and started in 1932. There's some debate about the second program because some were approved by a university but phased in and others had later approval, but started before. Northwestern, Michigan, Yale, Minnesota were all in that cohort.

AP: When did ours begin?

JW: In 1946.

AP: Am I correct that it was part of Public Health?

JW: That's correct and Mr. Amberg was on the faculty. That becomes an interesting part of history that I'll get to later.

AP: Good. The key date in your career was November 1966 when you took over the position that Gertrude Gilman had had?

JW: In terms of the directorship of the hospital.

AP: Right.

JW: In terms of my knowledge of the health sciences, I would say, probably coming back to head up the planning effort. I had a Hill Family Foundation grant to plan a new clinic when I got back in 1964, but Dean Howard, to his credit, and the president of the university, Meredith Wilson, wanted a Health Sciences Planning effort. In other words, they didn't want the Medical School, the hospital, Pharmacy, Dentistry, Public Health, Nursing all planning their own buildings.

AP: So, you are really the author then... In the interviews, uniformly people are extremely pleased with the way those units came on line and the way the concept of the integrated health sciences developed. Where did you get the idea for this? Was this copying some kind of model that existed?

JW: No—I'd be very careful about giving me so much credit—there was an unusual number of people who were disinterested in their own egos who understood the health sciences concept. So, as I looked around the country, I reported back to the deans that other universities were virtually unable... I think of the seventy-six academic centers I surveyed, I could only find three or four that could put together an integrated program and most of those were brand new schools where there was no tradition. That was part of the condition of employment [unclear] you're in the Health Sciences. A lot of credit goes to Dean Howard because the College of Medical Sciences, which had Public Health, Nursing, and the Hospital underneath it, in a sense, was abolished and Dean Howard sacrificed his own job to see this concept come forward. Larry Weaver, over in Pharmacy, and Erwin Schaeffer in Dentistry could not really deliver their faculties as long as the dean of the Medical School was also the dean of Medical Sciences—if you understand that.

AP: Yes, yes.

JW: So the University of Minnesota became one of the very first to create a true vice-president for the Health Sciences office that not only had all those academic units but we also had Vet[erinary] Medicine sit in with us as an affiliate, I think. [William] Thorp was the dean of Veterinary Medicine. The reason there was there's a huge tie between basic sciences and the Veterinary Medicine School. Schaeffer and Weaver, to their credit, delivered their faculties into the Health Sciences. Howard let it happen. Is Bob still living? I've lost touch with him.

AP: I don't know. I'll try to find out.

JW: Perhaps, he was willing to give up the deanship of the Medical School, thinking that he'd be the vice-president; but, as it turned out, Lyle French...

AP: Was chosen.

JW: Yes. He, probably, was somewhat of a long shot when the whole Health Sciences Planning effort started. He got everyone's support because he was on the—whatever we called it—steering

committee of Health Sciences. He was chairman of the Clinical Sciences Planning group. The way it divided down was each school had a representative on the planning group. The Medical School had three really: it's dean, the chair of Basic Sciences Planning... I don't think it was [Maurice] Visscher. I don't think it was Wally Armstrong. I can't remember who that was. Lyle will know.

AP: I'll ask Lyle.

JW: And Lyle had the Clinical Sciences. See, he had the opportunity for two years of this intensive effort of demonstrating his statesmanship qualities. Also, he was in the unique position of speaking up to anyone in the Medical School who, perhaps, had a somewhat unreasonable request. He could handle them. Bob Howard had been somewhat bruised, too. There was some faculty private practice plan that I'm not too aware of, but I know, as I interviewed the faculty and worked with them over the years, they felt that Dr. Howard was not enormously supportive of private practice. He thought it might weaken the school. As it turned out, that was just the trend that carried the university and other academic centers into strength in the 1970s and 1980s.

AP: You mean the private practice understandings?

JW: To which they could harness that and make it work to their advantage.

AP: Your view is that Howard was maybe not on the cutting edge of that issue, more conservative on the private practice opportunities?

JW: Yes, I think he came from an older school, a Mayo Clinic School maybe, that said, "Wouldn't it be nice if we were all salaried the same amount of money and wouldn't have pressures on us that would detract from our research or investigation and from our publications and from our teaching of students?" There was, what I would call, a more purist school, which thought private practice was a detriment. I ended up coming down just on the other side, that you couldn't run an academic center without a substantial private practice and the object of the game was to emulate Mayo Clinic's [unclear] as possible and emulate the University of Minnesota and have the most unique service as possible so that people would have a reason to come to you. When our Health Sciences was formed... I think it was 1971...

AP: Yes.

JW: It was really formed back in 1965, when it shifted from Bob Howard's office to President Wilson's office. There's a wonderful man named Elmer Learn... Did you know him?

AP: I didn't know him, but I've certainly heard of the "Learn Report".

JW: He chaired the committee of all the deans in the Basic Sciences and Clinical Sciences [unclear]. He was a wonderful person and he was the president's assistant and that's really who I worked for.

AP: Do you remember his field?

JW: Yes, he was Ag[ricultural] Economics and left the university. He eventually became the president of UC-Davis.

AP: That's interesting. I didn't know that.

JW: I think he went there, perhaps, as [unclear]. Another person that might remember some of this is Ann Bailley. Do you know her?

AP: Sure.

JW: I thought you did. Ann's got a good memory on some of this stuff. There were several things about it. We became kind of a model for the country. I had a lot of inquiries and traveled a lot. Every place we went, people asked about the Minnesota model. One of the reasons they asked about it was there was a huge shortage of health sciences personnel projected by a number of federal government reports starting in about 1962, 1964, 1966, 1968. There were three or four reports out there that all forecast a gloom and doom. There was a lot of federal money available for construction of facilities that would increase class size. So, the Minnesota Medical School, for instance, went from something like 160 to 239 students. We created a medical school at Duluth. Mayo created their medical school at the same time, which was a University of Minnesota Medical School, closely affiliated. At the same time, Dentistry greatly expanded. Schaeffer went from 60 to 120 students or something. Pharmacy expanded. I'm less certain whether Nursing had the constraints on their class size. I used to make a lot of trips to Washington and work with Senator [Hubert H.] Humphrey and received a disproportionate share of federal funds for our buildings because when I went in to the surgeon general, who was a friend of Dick Magraw [Psychiatry], he said, "The reason you guys are doing so well is you have one of the few integrated health sciences plans. We don't want to give you the money. We'd rather spread it out equally; but, we have restrictions on how we can spend the money and the federal guys in their wisdom say, 'We're only going to give it to integrated places. We're going to look at one application from a university. We're not going to look at seven from the different health sciences.'"

AP: So it gave us a strategic advantage?

JW: A <u>huge</u> strategic advantage. In these schools without that cooperative spirit, people just would refuse to buy into any sort of health sciences because the non-medical school people didn't want to be dominated by the medical schools and medical schools said, "We are not going to have a health sciences led by a pharmacist, nurse, public health." There was a standoff in a whole lot of these places. They, generally, came around and I think by the mid 1970s, a variation of a coalition of the health sciences units became the practice in the United States. I think there became seventy to eighty such units in the United States.

That also led to a less publicized thing. We had integration of education. We had a number of teams that looked at, how can we best integrate our Clinical Sciences education? Basic Sciences, as you know, were pretty well integrated even back to the 1930s. Basic Sciences taught pharmacists, nurses,

dentists—sometimes in separate classes. That was pretty easy to bring about. Minnesota became one of the first, if not the first, schools to have Pharmacy students on our clinical floors at University Hospitals. Of course University Hospitals played a very key role in all of this because we really belonged to all of the health sciences, not just to the Medical School. We had an obligation, to the extent that it was useful, to be open to Pharmacy, Dentistry, and of course Nursing. That's always been a strong tie. But bringing in Pharmacy and Dentistry were huge. There was a graduate Pharmacy student on every floor. They were called Pharm-D.'s. Dr. Weaver can tell you more about that. He was very instrumental in getting that started. The residents loved it because there was an explosion of science and technology in the field of pharmaceuticals. To have someone there who was really on top of it just serving you as an intern or resident was terrific. So I'd say there were many benefits to that.

With the School of Nursing, primary nursing was founded at the University of Minnesota. That was a very important concept.

AP: Can you explain what you mean by primary nursing?

JW: Marie Manthey, who lives in town, might be worth a phone to her call on that.

AP: Okay.

JW: She and Dave Preston, whom you may have talked to.

AP: Yes, I have talked to Dave.

JW: He used to work for me. They started something at University Hospitals called Station 32. They made that a teaching laboratory for Nursing. They wanted to look at the effectiveness of measuring services on the station, which were effective, and then to use it as a base for trying new programs. It was called Project 32. They had committees. It was really quite well done, way ahead of its time.

AP: About what year are we talking?

JW: In 1969. It might have started in 1968.

AP: But in 1968, 1969, it began measuring the outcomes and monitoring the Nursing practice?

JW: Right. They had disciplines on their advisory committee from Environmental Health and Safety, Public Health, Nursing, Industrial Engineering, Clinical Psych[ology], Hospital Administration. That's what Marie built her career on. She, subsequently, went on to become director of nursing at Yale and, then, came back to Minneapolis and runs a consulting firm.

That was an outcome of that Minnesota cooperative spirit, as it got to be known around the country. People used to almost make sport of the Minnesota cooperative spirit, as we'd come up with one

innovation after another. All the people that worked in the hospital administration and hospital management also had a faculty appointment in a school. That greatly enhanced the cooperative spirit. There was a fellow named Tom Jones, who was a pharmacist, who was on my staff. So, Weaver gave him a faculty appointment and he worked with Hugh Kabot, who was on Larry's staff in the College of Pharmacy.

AP: Is that C-a-b-o-t?

JW: I think it's K-a-b-o-t.

AP: I can check in the directory.

JW: That really facilitated Pharmacy programs coming into the hospital. Of course, we cleared it with everyone involved: Nursing and Medicine. But, everyone was in a very cooperative spirit in those days. Similarly, I taught in the program in Health Administration in the School of Public Health. Another fellow on our staff had an appointment in Clinical Dentistry because we had a small dental clinic that did oral surgery. Then, of course, our director of nursing had an appointment had an appointment in the School of Nursing. The idea was that the University Hospitals and Clinics—we changed the name from University Hospital to Hospitals and Clinics—would serve all the health sciences units to the extent possible, not just the Medical School. That was accepted by all the faculty units as long as they worked on the design of the program and it wouldn't interfere with their programs too much.

Then the hospital had another role. There's a book Owen Wangensteen edited about Dean [Elias Potter] Lyon.

AP: Yes.

JW: In that book about Dean Lyon, you'll see that the faculty didn't want to be just another land-grant university medical center. The Basic Science faculty led the way, so Minnesota was one of the first schools in the country that their residents were graduate students, were actually enrolled in graduate school and pursued doctoral degrees. Enrolling in graduate school was universally acclaimed around the country, but pursing doctoral degrees wasn't, the Ph.D. in addition to M.D., except for those 10, 15, 20 percent that were going into academic medicine. Nevertheless, that pattern was established back in the 1930s and 1940s.

AP: Am I correct that more of the Minnesota residents then were pursuing both a Ph.D. and an M.D. than would have been typical?

JW: Residents are M.D.'s.

AP: I meant pursuing the Ph.D. Sorry.

JW: Yes, I would guess Minnesota had the greatest number of M.D./Ph.D. graduates. It would be interesting; I don't know when that was totally abandoned. I think when the size became too much, they recognized that the cost, perhaps, of carrying that on was too great and it was modified. I'm sure it's still an option at the university. The important people were Visscher in Physiology and Wally Armstrong in Biochemistry Oh, they had a wonderful bunch there in Basic Sciences. They were leading intellectual lights and worked closely with Wangensteen and others because they wanted the university to be not just another land-grant university, not another Nebraska, as they used to say. They wanted science into the medical curriculum. They wanted doctoral programs. They wanted to work closely with the clinical sciences on the science of medicine.

They got a big boost. The started that around 1932, as I recall from Wangensteen's book, and during the war, by the standards of the day, lots of money came from the Federal Government Defense Department for different studies in the University of Minnesota Medical School. Cy Barnham was another giant in Basic Sciences. The scientific base, because it was there in the 1930s and nurtured by the school and the legislature, was the recipient of a great deal of money during the war, so it became a very sought after place for residents to come. Indeed, if you look from 1950 on—I was there 1982—particularly in the mid 1950s, most of the residents were not Minnesota graduates. The chiefs recruited from schools they went to or faculties they had taught on, so a whole lot of them were from the East Coast, some from the West Coast, all over the country and that was kind of unusual. The medical students had different cultures in the sense that they were taught by interns and residents to a considerable extent and, now, these interns and residents were from Yale and Harvard and Columbia and California, all over. It was a local Medical School but with a national house staff. It was a very sought after position. They would have huge numbers of applicants. Lyle used to have 200 to 300 applicants for, I think it was, two positions a year in Neurosurgery. That was true in Medicine with Cecil Watson and Wangensteen. Everything built on it. So when the first wave of these powerful intellectual giants left, these visionaries, we were able to recruit very good people in their place, so John Najarian—whatever his later problems were—was acknowledged as a real catch in the Department of Surgery and put us on the map in terms of transplants. Sey Levitt...

AP: Will you spell that? Is that Cyrus?

JW: Seymour L-e-v-i-t-t. I think he's still there. Levitt came in Radiation Therapy. H.O. Peterson was very famous in Radiology and he was succeeded by a young man he recruited, Gene [Eugene] Gedgaudas, a Lithuanian. Cecil Watson was succeeded by Tom Ferris from Ohio State University. In program after program, they were able to recruit almost whomever they wanted. There were some monetary constraints. Again, because of Lyle's deft handling of the private practice plan, we could be pretty competitive with non-state universities to get the kind of person we wanted. Then, a whole lot of the development was done by the house staff that were going into the Ph.D. program. They did a lot of the research and cutting edge development things.

AP: You use the word "house staff" and it's not an expression that I've heard before.

JW: House staff is a hospital term and it describes a group called interns, which has been abolished now. That's the first year out of medical school and used to be a very good name until it was sullied

in recent years. They're called G-1s now. House staff all those who are training for specialty degrees and who work with the faculty to take care of patients and who, at Minnesota, were pursuing their Ph.D.s, were enrolled in course work.

AP: Would there have been other residents who might not have been engaged in a Ph.D. but were doing a rotation through University Hospitals or were all the residents, generally, Ph.D. types?

JW: At one time, it was a condition precedent. It was required that all of them would be enrolled in the Graduate School; although, it was understood for some of those at Ramsey and Hennepin County that beyond a few basic courses, they weren't expected to do their doctoral dissertation and so on. But, the argument was that the rigor and the vigor of doing course work while you're in a residency was far better than the old method of watch me...*see one, do one, teach one*. So, Minnesota pioneered in that.

AP: *See one, do one, teach one* was the old way?

JW: That was the old way and Minnesota said, "No, we think there ought to be structured course work with assignments and lectures so that people learn about the science of clinical medicine and they not forget that medicine is very dependent on technology and advancement and Minnesota was one of the leaders. University Hospitals was the laboratory for it. We often talked about taking things from the bench to the bedside in clinical trials and so forth. Minnesota, in all of their clinical departments, prided themselves on being on the cutting edge of clinical development. Indeed, of the departments—I can't remember how many departments, twelve or something—six of them were rated in the top fifteen. They had ratings come out all the time and Minnesota had very strong ratings.

In the late 1970s, I could see that starting to unravel a bit. The will to work together was still there but the federal government started passing laws that discouraged people from using hospitals. In a sense, Minnesota's vision in 1964... As we prioritized buildings, everyone agreed that the Basic Sciences and Dentistry ought to go up first because Dentistry had to vacate space so Basic Sciences could expand. The faculty, to its credit, in the Medical School, said, "We've looked at the future"—this was 1966—"and we don't need more hospital beds." Dick Magraw and the late Dr. Jim Carey were enormous leaders in this, and Richard Anderson, who is now Lajoya [New Mexico], and Lyle French supported this. [They said] "We need a state of the art clinic facility, Mayo Clinic type." So, the university allowed us to hire the Architects Collaborative of Cambridge, Massachusetts, which is the old Walter Gropius group [unclear] worked with... Our university architect assigned to it was Hugh Peacock. He was very instrumental in this. The Health Sciences Planning was kind of a fusion of architectural ideas, economics, looking at the future. The ambulatory building went up long before the new hospital went up, which was fortuitous because, by the time the hospital was built, it was clear that you didn't need the beds that we thought we'd need even in the early 1970s.

AP: Can I skip ahead to the hospital question? One of the things that seems to have happened is that... [C. Peter] Magrath said that one of his most successful decisions was an eleventh hour reduction in the size of the hospital and it apparently came about by some articles in the newspaper

arguing that the university was over-exaggerating our needs. Does that ring a bell with you? Or that may have been after your...

JW: I think it happened after I was gone. It doesn't surprise me. What happened is it was kind of a no brainer decision. It was clear that we didn't need that and it was clear when we went into the 1978 legislature and it was clear when we went into the 1980 legislature. The legislature in their wisdom said, "Just leave the package here and we can adjust it later." The big push was for legislative funding, which I was not enthused about because by then the private market was willing to loan money—I talked to several investment banks. University Hospitals, on the strength of our revenue flow, was a very successful place and had good strong operating margins, which is a not-for-profit terminology for profits, all the years I was there. We funded quite a bit of money actually. Greg Hart can tell you more about that. I wanted to go to the private market and worked with Jim Brinkerhoff and Larry Lunden before him. The legislature felt very proprietary about the hospital. They liked it. They felt we should play that card out by having the plan wedded to legislative votes. This went on for a period of two, three years. I recall kind of staying there the last three years just to get the vote through. [laughter] Then, they never did use the authority, as I recall. They went to the private market anyway. That locked in a plan before the legislature and, in a sense, it retarded what should have been done, which was to cut down the size of the project, which everyone knew. It was well understood inside and that would have happened in any event.

AP: That's interesting.

JW: There wasn't anyone that didn't understand that. By being led to legislative support several things happened. There were critical developments that we wanted to make in 1978 and 1979. A number of very bright, good [unclear] graduates graduated and it was clear to us by the mid 1970s that we had to become more like Mayo Clinic and everyone talked about that on the clinical side.

AP: What do you mean exactly?

JW: Service-oriented, patient oriented, make it easy for patients to get in, put up those parking ramps which you finally got up, and get people coming back to us for their checkups and taking care of a large volume of patients. Well, again, you had the natural conflict of more of the purists who said, "Wait a minute. We're here to teach. We're here to advance new knowledge. Patients are a necessary evil." That used to be the kind of old-fashioned purist approach. That never carried the day. By the late 1970s, we wanted to set up a University of Minnesota physician group who were not on a tenure track for faculty. They would just have clinical appointments. We had excess capacity in our clinics and could build more, could provide space that this group would, then, be able to compete with any group in the Twin Cities and people would be assured of getting Mayo Clinic type care at the University of Minnesota Hospitals and Clinics. So, it would be competitive with—I can't remember the clinics there; they change the names so much in Minneapolis—the old Park Nicollet. I had a bunch of friends that practiced at the St. Louis Park Clinic. That was the model. There were a lot of young guys who would come out and they'd come up to me and say, "Any chance we could stay on the staff here?" As long as it was [unclear] faculty appointments, it was up to the chief and, understandably, the chief didn't have much room. He couldn't afford to pay a large number of people.

Some of the chiefs were less patient-oriented, as time went on. So, that idea never got off the ground. It got a lot of support from a lot of people. It could have passed through the Medical School. It could have passed within the Health Sciences group. Dentistry and Pharmacy saw roles for themselves. But, there was a fear by the people working closely with the legislature that it would upset the State Medical Association for us to be going into pure practice.

AP: I see.

JW: And, therefore, our funding would be jeopardized. Again, that funding issue with the legislature came back to haunt us. We were just locked into that and it didn't really serve us well. I think it would have been probably better if we'd been more imaginative and gone to the private sector earlier because University Hospitals had strong enough balance sheets.

Also, remember in January 1975, we were the first university hospital in the United States to create our own Board of Trustees.

AP: Oh, really?

JW: Yes! The idea there was very simple. The Board of Regents was wonderful. They couldn't have been more supportive of the Health Sciences and University Hospitals in particular. But, as a whole body of accreditation and demands came up, a body of case law, a body of looking at our competitors around the country in the private sector, the University Hospitals were not well-served by the Board of Regents who maybe only took up their budget once a year. That wasn't governance as required by the new forces of the 1970s and 1980s. I guess you've probably seen more and more of that. So, we were the first . . .

[End of Tape 1, Side 1]

[Tape 1, Side 2]

AP: . . .Pillsbury.

JW: And Al Hanzer. We had the board set up. I think we had three or four people from the Health Sciences sit on it, ex officio, like Lyle and the past chief of staff of the hospital, to give some continuity there.

AP: Can you help me on terminology? Chief of staff. Is that one of the clinical chiefs who is the head person?

JW: Yes. All hospitals have a chief of staff elected. This was another Minnesota twist. Usually, it's a person who doesn't want the job because it can detract from his or her private practice and it's unpaid in most places. They have it for a year, bundle up their problems and pass them on to the person who comes next year; so, it's not been an enormously effective post in many hospitals in the United States, the 5,000 to 6,000 hospitals. We looked at it and said, "Let's do something different."

I would like to pick up part of their salary recognizing that it is one third to 50 percent—let's not argue about that. So, we picked up part of the salary. We also said that we wanted some continuity, so we had three-year terms with the person eligible for another two years. We had perfectly marvelous chiefs of staff. It was amazing! It was very democratic and the medical staff always came up with someone who was wonderful.

AP: Can you remember who some of them were?

JW: Sure. Paul Quie was the last one when I was there. Paul Winchell was, I think, before Paul Quie. He was a marvelous chief of staff, as was Paul Quie. Then, before that, was Donald Hastings.

AP: He was a psychiatrist, right?

JW: Yes. Don was a terrific guy, a good chief of staff. They were all elected so I guess those are about the three for the fifteen years that I was there. They did a terrific job.

AP: Now, the clinical chiefs are the people like Wangensteen and Najarian?

JW: They wear two hats. To put it simply, their academic hat is professor and chairman of Department *X*. In that capacity, they report to the dean of the Medical School. On clinical service, they are responsible to the hospital. The leadership for the Health Sciences getting together, I must say, really came from the deans and some senior faculty members. By and large, when I arrived there, Pharmacy knew very little about Dentistry, knew very little about Medical School. They were independent fiefdoms, not hostile, not angry, but not understanding; so, a huge part of the early work of the Health Sciences would be to get the faculty leaders in various places to just explain some of the programs and what they were doing and where dental education was going and where pharmacy education was going. Those were wonderful sessions that really brought a sense of harmony. The clinical chiefs, similarly, while they participated in the faculty meetings, never really got together about hospital business, patient service; so, we started luncheons every Tuesday for the clinical chiefs. We had representatives there from Nursing, Pharmacy, and Dentistry. We would put out *Wall Street Journal*, the *New York Times*, and *New England Journal of Medicine* articles so they would know what was going on in the real world. When I first started those, it was amazing the chitchat over the little buffet lunch that was set up. These guys didn't know where each other lived. They didn't know anything about each other's children. Someone would say, "Did you have a nice weekend?" "Yes, my son-in-law and..." "Oh, you have children? How many children do you have?" [laughter] It was a real way to bond them together and get them working together.

AP: Who were those first generation of clinical chiefs around that table?

JW: When we started it in 1967 or 1968, I can't remember if Najarian was there then, but he was certainly there for most of it. H.O. Peterson . . .

AP: Is that P-e-t-e-r-s-o-n...or e-n?

JW: Oh, boy, I think it's o-n.

AP: H.O. is...?

JW: Harold Oscar.

AP: What was his field?

JW: He was Radiology. Then, the aforementioned Seymour Levitt in Radiation Therapy was there. John Najarian in Surgery. Wangensteen was just leaving as I got there. In fact, he may have designated [Richard] Varco for a year or two. Do you know when Najarian got there? I was thinking it was 1968.

AP: I've got a file, but I don't have it right in front of me at this moment.

JW: Lyle French represented Neurosurgery. Tom Ferris represented Medicine. Laboratory was Ellis Benson. Pediatrics was John Anderson. Rehab was [Frederic] Fritz Kottke. It was very informal and was a non-decision making group.

AP: It was the socialization of a lunch and discussing...?

JW: They started out saying, "John, good idea, but do you realize how busy we are?" Several of them had clinical conferences. Obviously, I couldn't pick a day when [unclear] clinical conference. It was very interesting that within six months, they wouldn't miss it and they would change their schedule. I let them set the day; Tuesday happened to be the best for most of them. They didn't want to miss out on what was going on. Once in awhile, there would be a guest in town and we would have the guest come to lunch and talk to us about what was going on wherever they were from or in whatever field they were in.

AP: That's a very interesting kind of institution. I bet there were no minutes?

JW: No. That was part of the deal. There would be handouts, which we kept for years and years. There was an agenda. I wanted a little structure to it.

AP: If I were to try to look for one of those agendas, what would I look under? Would they call it the Tuesday Meeting or...?

JW: The Clinical Chief's Meeting. I would guess that most of them have been thrown out. We kept them in the director's office for years, but I left there in January 1982 so it's been a long time.

AP: Have they continued it?

JW: The whole nature of University Hospitals changed. When we got tied up in the legislature, I felt we lost some momentum in 1978, 1979, 1980, 1981, in that period. We'd been so innovative, as

I've indicated to you, in so many ways and, now, we felt stymied, that we couldn't set up that physician group. That would have been wonderful for the university. It would have been able to allow us to respond to all the changes. We could have set up a managed care thing. At one time, people flirted with us about taking over student health. We could have done all sorts of things with that, expanded into the neighborhood. You can't expect the faculty to do that, but this group could do that. We had a lot of contacts out there. We created one of the first university community clinics. Dr. DeFoe in Pediatrics and Dr. Branthaver in Pediatrics set this up. It was called the Community Clinic. It was right in the midst of the large Native American population over in Riverside.

AP: I remember that.

JW: We wanted to do more things like that. We had a network of fourteen or so hospitals in the state that we were tying together and, eventually, without the medical manpower to visit and nurture those relations, Abbot Northwestern took it over. I felt and many of us in management and a lot of the faculty felt that those lost years really set us back. I think, to some extent, some of the more conservative forces took over. Remember, if you're a tenured faculty member and life is pretty good for you and your income doesn't depend on taking care of patients, clinical service is a nuisance. It's messy. It's got to be done twenty-four hours a day, seven days a week; but, that's what we're in the business for. The hospital was always kind of the [unclear] conscience, as it were, of patient care. We were probably over-enthusiastic about doing things like that, but I believed that by 1975, 1976, the idea... You may recall the State Medical Association had a lot to do with the setting up of the Medical School and Hospital in 1888 or 1892. They <u>deliberately</u> placed it on that god-awful site on the river so it couldn't expand. That was a condition of supporting it. Organized medicine was never all that supportive of the hospital on the clinical side of things. We were always conscious that there's going to be opposition as we tried to keep up with the rest of the country in terms of outreach programs and serving community needs and linking up with public health and all those good things. We had to be very discreet and careful. When we didn't come forward with a continued set of vigorous programs... Remember now, we had the board. We had integrated Health Sciences. We had integrated education. We had integrated research. It was still a very productive place. When I left, we were in the top six in terms of research funds. I worked with NIH for six years as a site visitor. I'd go around and I'd ask lots of questions about research and so forth. Minnesota was in the top six, so we were doing everything right and needed that enhanced clinical component and, maybe, even some outreach clinics. Greg Hart picked that up, but I think, by then, it was too late.

AP: It was the legislative and practitioner opposition that hedged you in?

JW: Perceived.

AP: Oh, I see what you mean.

JW: That was kind of the beginning of the end, as I look at the history of University Hospitals. I was thinking of that the other night. I'm reading a virtual history. I don't know if you read history much, but there's a wonderful historian named Ferguson, who just published a book [*The Pity of War*] about the tragedy of World War I.

AP: I haven't seen it.

JW: Ferguson is very famous. He's a young pup, an Oxford historian. He's written a book, a virtual history, *Alternatives and Counter Factuals*, or something like that. It had to do with *what if?* What if things had gone a different way? Minnesota...I felt the clinical side of it, particularly when Lyle left, was just choked off. You can't lose momentum in this business. If you don't keep up, there are other people who will move in. I think Greg was frustrated, too, that there were certain programs he couldn't implement and, then, of course, now, in kind of a tragedy, Fairview should have been part of University Hospitals. In fact, we had talked about buying other hospitals. Fairview is a very undistinguished place...a lot of general practitioners there and they weren't filling beds. They invested a lot of money in PR [public relations] and they did very well with their little 250-bed Southdale Clinic and Hospital, whatever that's called out there. They had specialty care there, but the one across the river from us didn't. We could have even leased beds there should the program of university graduates and physicians who wanted to join the university group... We could set that up. By the way, just shortly thereafter, Harvard did that. Yale did that. The University of Pennsylvania did that.

AP: Can you review that for me, because I'm not sure I completely understand?

JW: One of the problems of the clinical side, clinics and hospitals in academic centers, is there aren't many rewards for seeing a lot of patients. Thank goodness, under Lyle's steady hand, we had a private practice plan that made Minnesota on the more liberal side of that; that is, our people were willing to see large volumes of patients because they had a lot of house staff and so forth. But that getting out and competing for patients... Older faculty who tended to be in senior positions remember the days when, as late as 1959, 1960, you couldn't get into University Hospitals, unless you had a referral. That was because that was the deal. The State Medical Society didn't want any practice, so the only patients that came to us were there for teaching purposes. Well, that was a fiction by the time I got there in 1966 and we just quietly abandoned it. First, with Donald Hastings' help, we dropped the policy for Psychiatry. Then, with John Sherra's help, an OB-GYN [Obstetrics, Gynecology] man, we dropped the policy for OB. You need to have an engine like Mayo Clinic that says, "We'll take care of everyone who comes through the doors. We're here to serve. We're here to give patient care and the more, the better." That wasn't in the nature of a lot of academic health centers and Minnesota had one of the toughest obstacles to overcome: of the 100 or so academic centers, it was the only pure referral one. By 1966, when I was there, no other one had that and, of course, your big East Coast ones treated the community. Yale in New Haven, Mass[achusetts] General in Boston did a lot of primary care in the neighborhood. Mass General, I thought, was a good model. I knew a lot of people there. They had a wonderful combination of gifted private practitioners and academics working side-by-side. Minnesota needed that blend and the older line faculty would say, "We have that at St. Paul Ramsey and Hennepin County." To some extent, that was true; but, it really wasn't the 1990's model of medicine we needed to get to. So, that was the beginning of the end for strong clinical service until I guess it was taken over by Fairview.

AP: I always wondered why they didn't merge with Abbot Northwestern. There was a time when the contracts were up and they actually looked very carefully at both and finally chose as their partner Fairview.

JW: I think Greg Hart would know more about that from the outside. Once I left the university, I took other busy jobs so my knowledge of history, post-1982, is slim. Fairview had a lot of general practitioners so they were more compatible with our specialists; whereas, Abbot Northwestern thought of themselves as just as good as University Hospitals; they were all specialists. In fact, they thought they were replacing University Hospitals as the premier health provider. That's why we needed the response, at the time, to slowly build up our clinical arm.

AP: That makes sense then. It certainly is a different world.

JW: A different world.

AP: Are there any sources that you would suggest that we look at? One of the challenges in this book is to make sure that we include in the bibliography and also discuss an institution like a university hospital in a way that—let's just imagine that some visitor comes from England and doesn't know anything about American universities and anything about American medicine—we would have described what we were doing in Minnesota in a reasonably sensible way.

JW: I think you're about that now. I don't know if I have any papers about University Hospitals.

AP: There's something called the "Learn Report," so I'm going to check that. I think that you all produced a study and I think that will probably be . . .

JW: That has some. Let me look through my garage files. You gave me your address once, Ann. You're going to send me something, right?

AP: Exactly.

JW: Put it in that. It will take me a few days to rummage through there and to pick out.

When I used to talk to Stan Nelson, I thought their role was to provide excellent specialty service but not the super specialty service—or quaternary as it came to be called—that University Hospitals could. We could do both; we could do quaternary and we could do great primary care, in other words, things that are being brought from the bench to the bedside: clinical trials and stuff. We were well set up for that. You did not need a huge Abbot Northwestern institution. There was a fair amount of antagonism, more on the Abbot Northwestern side I think, toward the university because the university was thought to have an attitude—to be sure, some faculty members did, particularly in the days when it was more of a referral hospital, till we abandoned that quietly service by service. As the professor would teach, they would often have to indicate why the patient was referred to University Hospitals. It was often referred to University Hospitals because the LMD, local medical doctor, made a mistake.

AP: That would be an uncomfortable structure. Yes, I get the picture.

JW: The residents were always counseled on being very careful about that during orientation sessions when they came. We said, "This isn't New York. This isn't Boston. This isn't Philadelphia. No LMD makes a mistake. They've always done the correct thing and you are to start from that premise. If we ever hear any of you"—Al Sullivan used to give this talk—"criticize an LMD, we'll never get patients from that doctor again." It does get back to them. The medical community is a small community. The LMD is sometimes called RMD, referring medical doctor.

AP: One of the things that we're hoping to describe in this book is grand rounds and what it would have been like? I've had some descriptions from nurses and various people. Could you reconstruct for me, if you would, what this would been like? Pick one of the specialties, Surgery or Pediatrics.

JW: I've been on grand rounds, but I'm not your best source. I'll give you a lay person's... In the old days—we all worked Saturdays, by the way—they were held Saturday morning and the resident would work with the chief or the chief's designee. They would pick a couple of very interesting cases. So, this entourage would go visit someone with an unusual disease.

AP: I've been led to understand that it would include the nurse on the floor as a courtesy so she would be informed.

JW: Minnesota was more liberal than that. By the time I started in 1966, nurses wouldn't think of standing up for physicians. They were very liberated. They also had their own system if a resident started hassling them: Every nurse would drop what they were doing and come and stand by the nurse and have confrontation. Some of the residents from the East Coast tended to be a little abrasive. I guess those were the days of short skirts and one of the senior professors in Medicine came into my office very serious and wanted me to pass a rule that these nurses couldn't wear short skirts. That must have been the style in 1966, 1967. Can you remember?

AP: Vaguely, vaguely, yes.

JW: [laughter] I was just stunned for a moment. I said, "Certainly, that's a very reasonable request. Let me talk it over with the Nursing staff. I know what they're going to say." He said, "What's that?" I said, "If the physician's will shave their beards and get hair cuts, they might be willing to consider setting some standards. Can you get to your residents to control their dress?" He [unclear] and sputtered and walked out. [laughter] So, that was the end of that.

After the cases were presented around the bedside, they'd then go out in the hall and discuss them, because it was quite a large group. Then, they'd retire to an auditorium or classroom of some kind and say, "All right, let's talk about this." There would be formal presentations of what they'd seen and what had transpired. They also had M & M conferences. What was it? Mortality and ... people died.

AP: What's the second *M*?

JW: I can't remember.

AP: It was to figure out why they had died?

JW: That was a very good part of medicine. Maybe it was Morbidity and Mortality conferences. They'd review a couple of the interesting cases. One of the huge strengths of academic medicine, and particularly Minnesota, is the honesty with which physicians deal with this. In private practice, it's a different world. You don't want to get up in front of other private practitioners... You won't get any referrals if you say, "Yes, I screwed this up." The senior faculty member, or clinician in charge, always took responsibility for any mistakes; although, most of them were made by young interns and residents. That was just the rules of the game and it made it easier for everyone to discuss.

AP: The entourage would have been the clinical chief, the residents, the interns, the nurse on the floor...

JW: Medical students and a few senior faculty.

AP: Did you have to be invited or could you just trail along?

JW: Oh, no, they were pleased that I would have any interest.

AP: I meant anybody. Could anybody or was it...?

JW: Anyone who could. At Minnesota, and Lyle French was great at this, it was a very interdisciplinary place. In other words, things weren't just Medicine or Surgery. If there was a physiology problem, we'd invite Visscher to come along and comment on it or someone from a different department. Increasingly, even when I was there, things moved away from... It wasn't so much Medicine, Surgery, Peds [Pediatrics], which are artificial distinctions. As Lyle was fond of saying, "These are academic departments." That's not how you classify patients. Patients have cardiovascular problems or they have neurological problems, or they have things that cut across four of five specialties.

AP: Is there any kind of anecdote that we could tell that might help for readers? I'm thinking of a Jamie Fisk story, some kind of human story, which would describe how all of this worked. Can you think of anything that we were known for?

JW: Oh! we had a whole number of firsts. When I came, we were quite well known for our pioneer work in the cardiovascular area. Wangensteen and Varco and [Dr. C. Walton] Lillehei did open heart surgery and they did open heart surgery on high-risk patients. They didn't do the easy cases. Minnesota became very well known as a heart center. With Dr. [William T.] Peyton and Dr. [Lyle] French, it was quite well known in Neurosurgery. In Peds, there were more pediatricians on the staff at Minnesota at one time than there were in the state of Minnesota.

AP: What were we known for in Pediatrics?

JW: I remember bone marrow transplants for leukemia patients and, of course, pediatric cardiovascular and cardiology. Al Michael...have you talked to him yet?

AP: Not yet, but he's on my list.

JW: He'll be the one.

AP: He's in Pediatrics, is that right?

JW: Yes, Al and Bill Krivit and Mark Nesbit. I remember all those guys. They were all over the place doing wonderful work in Pediatrics. Kids would come in that others had given up on and they really did a good job.

Dr. [Frederick] Van Bergen, who was chairman of Anesthesiology and a cohort of Wangensteen and Lyle knew him well, was instrumental, I think when I was a resident there, in setting up one of the first post-surgical critical care units. It used to be that people were taken out of surgery till they became conscious and then rolled back to their room. They set up this critical care unit where they observed and had protocol so people were under constant surveillance. They were doing things to them all the time. Dr. Varco is famous for walking his heart patients the first day after surgery, walking them up and down the corridors and he'd be talking to them.

There are a lot of very interesting anecdotes. The East Coast faculty and residents just couldn't get over the Minnesota patients. The East Coast people are complaining but if you try to get a history in Minnesota... They'd say, "How are you, Lars?" "Oh, fine." "Where does it hurt?" "Oh, I'm doing fine, doctor." [laughter] They said it was like pulling teeth getting these people to say where it hurt, getting a good physical history of what their problems were.

Minnesota pioneered in Laboratory. The guy before [unclear] was the father of the Clinical Laboratory. In the old days, laboratories did autopsies and maybe some tissue work, but, all of a sudden, high tech came along and Ellis Benson was kind of pioneer in that and Clinical Laboratories became an engine that drove the place. Minnesota is very fortunate because to be a great center, you have to answer questions about patients and you do that by looking at their blood and urine. We had twenty-one faculty members, I think, in Laboratory at one time. They had seven or eight subdivisions in Laboratory; so, any question you wanted to know, Benson's group could give you the answer. Before that, it was Gerald Ebbens who pioneered in the concept of the Clinical Laboratory. They used to be called the Department of Pathology Medicine. Clinical Labs became all the rage. They were, in the 1960s and 1970s, really the high techies in the field. Then, Radiology became high techie in the 1970s and 1980s. Minnesota always had one of the top five Radiology programs in the country with H.O. Peterson and, then, Gene Gedgaudas. People were always giving us the latest equipment to try. We were the cutting edge. They said, "If we can sell Minnesota, then, we can go out and sell 500 to 600 hospitals," because they were all looking to what were we adopting. The whole hospital,

just about the time I got there, became a very high tech place. I remember we hired CHI Associates out of Michigan.

AP: How would you spell CHI?

JW: CHI. What we had them do was go through all our major departments and analyze the workflow. In those days, it was more efficiency. In later days, of course, it became quality control, twenty years later. We started that then and made every attempt to automate billing and laboratory reports in radiology and get them up on the floor the moment they were there. In the old days, what was irritating was the doctor would order tests and, then, he couldn't get the results till the next day. Patients, on the whole, would stay a day or two too long because no doctor's going to discharge until they're sure your tests are okay, that the reason you were in there has been solved, that the problem has been taken care of or modified. By going to high tech, we drastically increased our turnover in the place. We put monitors in all the stations so they could punch up results immediately in lab and x-rays. It was a pretty exciting time then.

AP: It certainly is a remarkable place, University Hospitals. We hope that in this book we can describe them in such a way that people will have a small sense of what they are.

JW: Have you talked Bob Dickler yet?

AP: No.

JW: He's a good person to talk to. He was on my staff. The reason I say he's a good person is that he's the number two person at AAMC [Association of American Medical Colleges], which is the national trade association of medical schools that have a teaching hospital component.

Minnesota was also—you probably don't want to talk to Dickler about this—one of eight founding hospitals for the Consortium for the Study of University Hospitals. That consortium was set up because academic hospitals truly are a different breed of animal and they don't have problems that other associations address. The AAMC has some 400 hospital members so Fairview can be in it and Ramsey can be in it and they're not the same as the academic health centers. Well, we signed on to that. Lyle supported it. It was somewhat controversial at the time; that's why we called it the Consortium for the <u>Study</u> of University Hospitals. We funded it; each hospital put in *X* dollars. Then, I think we got a grant to do some studies. We knew how it would evolve. It eventually evolved into a business organization and was the crème de la crème of academic hospitals. Then, they set up purchasing. Now, what we started out as on a volunteer basis has 76 members and 270 employees, and a huge budget, and all that good stuff. But, Minnesota was one of the eight founding members of that.

Did you read the Wangensteen book...Elias Potter Lyon?

AP: Yes.

JW: *Governing University Hospitals in a Changing Environment*, it was called. I'm sure you can get it from your library...by Tom Choi, C-h-o-i, Robert Allison, and Fred Munson. That was because Minnesota was such a leader in that. About three years later, by 1978, every university academic center, of which there were seventy-five, was faced with governance because, as I said, the accreditation standards demanded governance oversight. A board of regents just can't do that. They just have too much on their plate. Our board of regents... There's a wonderful gentleman in St. Cloud—who Lyle will remember—who was a lawyer...boy! he read through cases. I had lawyers come in and talk about case law and so forth. We studied it for about a year and a half. This regent couldn't have been more supportive...Fred something from St. Cloud. So, it was passed by the regents in September or October of 1974. We had our first meeting in January 1975. No, it was passed by the regents before then and...

Out of this consortium then, the university, in conjunction with other universities, took the lead in saying, "We want to go the next step and bond together these academic centers." The amount of money we were paying in consultant fees was enormous. The idea was that if we could share more stuff among ourselves, we could speed up the time line of necessary change. We could also share strategies because we weren't competitive with one another, which was kind of unusual. We could share strategies of surviving. The University of Wisconsin had particular problems in Madison. Iowa had different problems in that rural state. Michigan was out in Ann Arbor but was always worried about Detroit next door. That book was published and, then, three years later, they redid the bylaws and it became University Hospital Council or Consortium. UHC is their name now. It was all out of that early effort that Minnesota was part of. Those were really wonderful days.

AP: This has been extremely helpful, John. As you can imagine, it's quite a challenge for us to try to capture all the different parts of the university.

JW: I know. I don't envy you.

AP: The piece that I find the most helpful... I'd like to return to it if you've got a minute or two more?

JW: Yes.

AP: I'd like to go back to your account of the Tuesday luncheons that you had.

JW: Okay.

AP: I think that imaging those giants sitting around the hospital...that's a remarkable thing. It sort of explains, to me at least, all the things that needed to happen for the Academic [Health] Center to come together. It's fascinating. Can you run that past me again? You started it as a lunch. You picked a Tuesday. You had all the clinical chiefs. They all gradually began to make it a priority. Can you remember any particular guests that may have been significant?

JW: We had a number of important guests that would come through, but, by and large, a lot of these guests had big egos and that didn't go down well with this group. The Minnesota style was to rough up anyone who was important. They were not the least bit deferential. I would often have people sit in and observe from other places and they learned a lot from our chiefs, but the chiefs did not like to be talked to about how great things were at the University of Pennsylvania or all the wonderful things at Boston and New York City. Nothing has ever happened in the world until it's happened in New York. [laughter] I would say it was a gradual integration. We'd talk about programs. We were thinking about this program. Would this work? What about that? You could save light years with the chiefs there because on a broad policy basis, they will agree to…

[End of Tape 1, Side 2]

[Tape 2, Side 1]

JW: …but, I think we could do more for the patient if you'd invest the money in our department. [laughter] So, it could be a very difficult thing. These chiefs, who really were kind of feared around town and feared by medical students, kind of prided themselves on eating up deans and being very macho and much in control of their own empire, group, and very famous in the world. They were very interested in the international and national scene and happened to be doing their work out of Minnesota. There was a little bit of that. To begin integrate them so they could see that all their services relate to one another was great. Lyle played a very key role. He was invited in both as a neurosurgeon to start and, then, as vice-president, he sat in. Mostly, he'd keep quiet, but when a log jam needed to be broken, Lyle always came up with the right phrase, saying "Why don't we consider this?" or "Let's look into this more."

It was also very useful that if something was big in the *New England Journal* [*of Medicine*], someone was really doing something important, I'd say, "How are we doing on this?" [laughter] That would put them on the spot. They'd put me on the spot all the time, too; obviously, that's part of the give and take. "Why aren't we doing that?" The chiefs almost always knew exactly what was going on. They'd say, "That thing that came out of Alabama? That's nonsense, John. That was eight months ago and so and so has been fired and moved on." They were always on top of it. They'd say, "We'd like to do that. We just don't have the right staff here." Every academic center can't do everything 100 percent. You have to pick and choose what you're going to do. The Minnesota style very much was if we got on the cutting edge of something, we would just pour all the resources at them we could. If they had a market edge in the region, that's fine. Other academic centers had this kind of funny notion of equality, of take the pie and divide it up by the number of faculty you have. That led, generally, to mediocrity because good people aren't going to tolerate that. The key to it is that there's always a 10 percent factor. No matter how gifted all those chiefs were 10 percent were really the leaders. The key was to find out who they were and what they were doing and to key your programs off of them.

AP: Did they know who they were, too?

JW: They all thought they were the 10 percent. [laughter]

AP: I see.

JW: And in some ways, they were nationally, but in terms of getting things done at University Hospitals in Minneapolis, there were certain key members who I wouldn't dare list because that would be too dangerous. You would know without their support, this isn't going to go anyplace.

AP: Interesting.

JW: Lyle knew who they were, too. It wasn't always the chiefs; it was, sometimes, people in their department, too.

The chiefs used to laugh about, what they called, the Tuesday Luncheon Reading Club because I'd have the *New York Times* there and whatever. I said, "I think it's important that you know." They said, "Fine, John." Some would read them quite seriously and ask me questions and others, of course, would just leave the reprints on the table and not pay any attention to them—but, most of them took the agendas with them. What we tried to do was have no surprises, particularly when the board came on in 1975. I didn't want to take anything to the board that the clinical chiefs didn't know about. Now, some clinical chiefs didn't do a very good job of communicating with others and their faculty, so they'd come running to me and say, "Geez! why is the board doing this?" I'd have to try to tactfully protect the chief and protect the board.

That Board of Governors of the University of Minnesota was a pretty wonderful thing for our day because they could ask questions as laymen that no one else could ask, even Lyle and myself—we could ask them but like a nagging fish wife or something. They would just innocently ask. We had a chief featured each month or a department. Usually, the chief came to talk about their programs, very educational to the board and very educational for me and anyone in attendance. Those were open meetings. Lou Cope used to come to them all the time; he covered them and the *Pioneer Press* covered them for a while. Cope was almost always there. They said, "You've made these assertions. How do you know that's true, Dr. Najarian?" [laughter] He'd go back and in turned out in some cases that he just didn't have all the evidence. We had several attorneys on the board. We had one from each region of the state represented. It was a very, very good board. Al France from Duluth, I remember, used to ask great questions. Hanger...Sally Pillsbury was a great questioner. She chaired what was called the Hospital Medical Staff Joint Conference Committee. Then, we had a Finance Committee. Harry Atwood was a wonderful chairman. That group, I guess, Fairview probably abandoned because Fairview owns the place now, so it's the Fairview Board.

AP: Yes.

JW: That board couldn't approach the regional representation or the intellectual depth. The University Hospital Board was really good.

AP: You're probably absolutely right.

This has been extremely helpful, John. I really appreciate your time.

JW: I'll get your card and I'll look for a few things to send you about that. Let me give you Dickler's number before I hang up.

AP: Oh, great.

JW: It's 202-828-0492.

AP: I will give him a call.

JW: Nice talking to you.

AP: Nice to talk to you. Thank you very much. Take care.

[End of Tape 2, Side 1]

[End of Interview]

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