Interview with Paul Quie

Interviewed by Professor Clarke A. Chambers
University of Minnesota

Interviewed on November 1, 1994
University of Minnesota Campus

Paul Quie - PQ
Clarke A. Chambers - CAC

CAC: This is Clarke Chambers again. I seem to be the only interviewer on this project. I'm interviewing this morning Dr. Paul Quie, who was Regents' Professor of Pediatrics at the University of Minnesota. It is All Saints Day, November 1, 1994. We're conducting the interview on a beautiful bright blue day in his office in 860 Mayo.

As I suggested, Paul, it's always nice to have kind of an intellectual or career autobiography. You can start wherever. My father was a doctor and he knew, he claimed later in life, that at age eight or ten he knew he was going to be a doctor.

PQ: Oh, yes. [laughter]

CAC: That's a recurring legend, isn't it? It may be true.

PQ: Yes, it is. It's a wonderful legend. I get embarrassed actually when I read the biographies of famous physicians because that was not the case with me. I grew up on a dairy farm in southern Minnesota. It was in a typical Norwegian-American community. My father was a St. Olaf student; he didn't graduate. My mother had been at the University of Minnesota. I was one of four children. There was no question that we were all going to go to college even though we were grubbing along on the dairy farm out there. I was born in 1925. In my early years, the finances were a big part of our life. I remember my mother making soap and sewing our shirts. [laughter] It was not a time when there was much prosperity. My two sisters are older and they started St. Olaf in the late 1930s. I finished high school in 1943.

CAC: Northfield?

PQ: Yes, in Northfield. My brother had finished in 1942 and he volunteered for the navy, was in their flight training program; so, I stayed on the farm then after high school and farmed with my dad.

CAC: Through the war?

PQ: Through the war, yes, from 1943 to 1946. Those were formative years I guess. I wasn't very proud of not being in the military; so, I actually stayed on that farm. There were months at a time between visits to town.

CAC: But you were really too young to be in the service if you were born in 1925.

PQ: Well, I was. When I graduate from high school, I was eighteen . . . in 1943. I was prime aged but I was deferred. I think the only thing that kept my pride is the fact that they calculated how much activity was involved in the farm operation, how many people could be deferred. The way that formula worked . . . my father and I were producing the equivalent of seven people.

CAC: How many cows were you running?

PQ: We were milking about 27 cows and we had about 250 chickens. We had 70 sheep and we were running about 100 hogs at that time. [laughter] Everything we raised on the farm, in terms of the crops, we used for livestock and for the dairy.

CAC: Milk is really your cash crop?

PQ: Yes, milk was the cash crop. We had a little flax once in awhile that we sold and we had some soybeans that we sold. Otherwise, it was milk.

CAC: That was early for soybeans. They took off after the war.

PQ: It was after the war. My dad was a progressive farmer. We had a combine early on. My dad lost his left arm in a combine accident October 3, 1940.

CAC: That wasn't very good for milking.

PQ: I did all the milking for those two years, every single milking for two solid years. You don't miss a milking or the evening. I guess patient care and conscientiousness about patient care has never been a problem . . .

CAC: [laughter]

PQ: [laughter] . . . because those cows were compelling. They needed to be milked twice a day no matter what. Anxiety nightmares, to this day, involve missing a milking and coming back

in the morning and realizing the cows hadn't been milked the night before. It was just a recurring theme. [laughter] Those were the early years on the farm. My dad was a very strict Norwegian, a role model who was exceedingly fair but exceedingly strict. My mother was a wonderfully kind person who saw the best in everything. I always had this sense that her love for me was totally unconditional. I think that had a lot to do with . . .

CAC: That sounds like strong Lutheran.

PQ: It was Lutheran. It was strong Lutheran. [laughter] That's for sure. Until I was a teenager, the church services were in Norwegian one of the Sundays a month and three Sundays, they were in English. We didn't skip the Norwegian Sunday, we went through all of them. I can't speak Norwegian very well. No, I've lost that skill.

Clarke, I went on then to the University of Minnesota for summer school in the summer of 1946 to try to retool a little bit. It had been since 1943 that I'd been farming full time. In 1946, my brother was home from the war; and he, and my dad, and a hired man were running the farm and I had a chance to come up here for summer school. That really did accomplish knocking the rust off a little bit. I learned how to read a little bit efficiently and I had a course in math; so, when I started St. Olaf in the fall of 1946, I had a little bit of a head start. I'll never be able to repay my dad and mother, and brother actually, for that vision to allow me to do that. I was not a pre-med then. My brother had been involved in scholarly work as a navy pilot and I hadn't; so, this was sort of an equalizer. We started St. Olaf together, my brother Al and myself, in the fall of 1946. We farmed, then, with my dad that first year. He had classes in the morning and I had classes in the afternoon; and we managed to operate that farm and finish our first year at St. Olaf.

CAC: Gosh!

PQ: My brother married between my first and second years and he and Gretchen lived on the farm. My dad and mother moved to Northfield; so, I lived at home then through my second and third year at St. Olaf. I think the biggest moment of my whole St. Olaf career was opening the mailbox and seeing that I'd gotten an *A* in math in my sophomore and an *A* in chemistry. I said, "You know, medical school is a possibility here." It was during St. Olaf that I realized my dad had wanted to be a physician.

CAC: Heavens.

PQ: He couldn't because his father, who was the person who homesteaded that land and came over from Norway in 1845, had become blind with retinal, macular degeneration. My dad developed the same thing while I was in medical school. I'll probably develop the same thing, too, because it's a familial sort of thing but it's not bad.

CAC: I guess not.

PQ: It's painless and you can always see; so, I'm not dreading that so much. That was part of the early years. My brother was farming. I was accepted at Yale Medical School during the beginning of my junior year.

CAC: St. Olaf had a good pre-med program at that time?

PQ: They always had a wonderful pre-med program, yes. The chemistry was competitive, physics competitive. I left for Yale then after three years at St. Olaf with quite a bit of confidence that I could make it because I'd made it through the St. Olaf program with pretty good grades. After the first year at Yale, I came back, and my brother and I marched in the academic parade together, and got our degree in 1950 from St. Olaf. At that time, they'd give you credit for your first year in medical school. That was another proud moment. My mom and dad were pretty pleased their two boys. The two girls had gotten their degrees before. From the University of Minnesota, my oldest sister and my other sister from St. Olaf; so, three of us were from St. Olaf.

But Yale, I want to tell you about that, Clarke, because that was really a terrifically important turning point, I think. Yale's Medical School isn't well-known outside of medicine, I don't think; but, it's a <u>wonderful</u> medical school with very small classes. There were just fifty-four of us there.

CAC: Heavens.

PQ: Starting the first week, the faculty had a tea in the afternoon for the students. The faculty wives were responsible; so, I suddenly became a colleague of these wonderful physicians, in terms of a social colleague, kind of in small talk, in addition to the science, and the exams, and all the rest of it that's part of medical school. We'll get on to Minnesota here in a minute. When I reached the clinical years there . . . it's pretty much basic science the first two years of medical school and, then, it's clinical science.

CAC: That's true everywhere?

PQ: Everywhere, yes. That's been since the [Abraham] Flexner Report in the 1920s.

CAC: Boy! that hangs around a long time.

PQ: Yes. That influence of a scientific base for a physician is so important and that was certainly true of all medical schools. The clinical years were terrifically rich for me because I felt that I was a colleague of my professors, and my attending physicians, and the obstetricians, and surgeons, and all. We as Yale medical students were total colleagues of theirs, not on a first name basis, mind you, but in terms of our approach to patients and our dealing with human suffering, if you will, disease problems, and diagnosis, and outcomes, and concern, we were colleagues. It was tremendous. It was a tremendous experience for me. I did well in medical

school and got one of the coveted awards at the end called the Miriam K. Dacy Award, which went to the student who fulfilled the promise of becoming or being the compassionate physician. We called it the Compassionate Physician Award. That was given to me, much to my surprise. That sounds a little bit like bragging.

CAC: That must have been from your clinical professors who observed your relationship with patients?

PQ: Yes, that's right. It was a terrific boost to the ego to have received something like that.

CAC: It's remarkable to have that relationship recognized by such a prize because most of us who have been consumers of medical services find frequently that it's lacking.

PQ: I think it is why they had that award and why Miriam K. Dacy herself probably left her legacy for that. Yes, I think that's true. We had a commencement talk a couple of years ago and the commencement speaker—it happened to be David Kessler who is now head of the Food and Drug Administration—looked out at this group of graduating medical students and he said, "I know that you're all going to be physicians but I think a very <u>small</u> number of you are going to true healers."

CAC: Ahhh, that's a good word.

PQ: Then, he talked about what a healer was. He admonished them that with attention to that part of medicine, more of them could be true healers. I was really taken with his talk here. I think that was about 1992. I had a difficult time deciding what I wanted to be the rest of my life. The reason for that is that my role model had been a physician in Northfield and he died while I was in medical school. Being a family practitioner and a partner of Dr. [ ] Meers was not part of the future; so, I decided that I would come back to Minnesota and take a general internship. We called it a rotating internship at what was then called the Minneapolis General Hospital, now the Hennepin County Hospital. It was then that I decided pediatrics was a career; so, I stayed on at Minnesota for a pediatric residency after the internship, and was going along okay in the residency, and was drafted in the navy in 1954. I spent two years in Portsmouth Navy Hospital as pediatrician and came back here as something that's called the chief resident. The chief resident is the person who kind of directs the other residents in pediatrics and it's a stepping stone to academic medicine. It was during that time that I decided I'd stay at Minnesota in a fellowship.

CAC: What percent of your class at Yale do you suppose ended up in the academy as distinguished from some kind of clinical practice or general practice?

PQ: I think 80 percent at Yale in my class.

CAC: Now, that would be a very high percentage?

PQ: An exceedingly high percentage.

CAC: Because it wouldn't be true of your graduates here at the university?

PQ: No, I don't think so. I think it's less than 50 percent, certainly. We were an unusual class for some reason or other, in terms of that particular question. That's a pretty perceptive question because I never thought much of it until someone noted that . . . in fact, it was Professor Shep [Sherwin B.] Nuland, who wrote the book *How we Die: [Reflections on Life's Final Chapter*]. When we were together, he said, "Your class of 1953 is astounding in that about 80 percent of you ended up in academic medicine." That's a little aberration there. I think it was because the opportunities were there. That's why it's such a perceptive question. It gets into the funding of medical schools. Just when we were finishing our training, which was about 1958 or 1959, the support for medical research greatly expanded, just about that time.

CAC: This is through the NIH [National Institutes for Health]?

PQ: Through the NIH and through a fellow, Jim Shannon. It's a shadow of a single person who had the foresight that this was a rich opportunity and why not the United States? Why do we have to go to Germany for training? Until then, everybody went for post graduate training to Germany, or England, or France. He said, "Let's do it here."

CAC: Even after post-war . . . ?

PQ: Just at the end. It was still a holdover.

CAC: People went back to Germany even after 1945?

PQ: Yes, for a few years.

CAC: Isn't that [unclear]. I didn't know that.

PQ: I had to have German under my belt in order to be accepted into medical school because so much of the scientific advances had been written in German. It didn't last long after the war, Clarke. I think that it was just a very short time. It was Jim Shannon and the NIH that established this tremendous capacity for both clinical work and medical research in the United States in the early 1960s.

CAC: Would the same trend be evidenced in other modernized countries?

PQ: No. No one has done it. And we're moving away from it, Clarke, to become more like the European system as we separate . . .

CAC: Who subsidized research in England, or Germany, or France then?

PQ: They had national research but they kept it separate from clinical care.

CAC: Ah! Say more about that then.

PQ: If Jim Shannon had said, "We'll build a wonderful institute of health in Bethesda, Washington, and we will have all the research dollars for buildings and recruit scientists here, he would have had a magnificent Max-Planck Institut of medicine in the United States. That's where he gets so much credit and deserves . . .

CAC: It decentralized?

PQ: He allowed the state medical schools and the private medical schools to establish their research programs in the medical school, taking care of patients, having faculty care for patients, and . . .

CAC: Have the research and the clinical practice go together?

PQ: . . . have them go together. It's kind of a schizophrenic type of existence for those of us who have done it all of our life; but, it's wonderful. People from all over the world come here for that.

CAC: Has it become a model for medical research and practice elsewhere then?

PQ: It has but it's very difficult to establish. I spent a Alexander von Humboldt time in Germany. The Max-Planck Institut and the institutes are separate and hardly the twain shall meet. Those people who have been in the United States are trying their best to establish it in these other countries. I think the Scandinavian countries are doing it the best . . . Norway and Sweden. In Sweden, the Karolinksa [Institutet] is their famous, wonderful research institute. They have patients there but it's a little separate. Here, all the medical schools in the 1960s had a chance to expand and Minnesota did it in spades.

CAC: Apart from this one individual, Jim Shannon, do you know what the political or cultural context was for that really remarkable decision?

PQ: It's really remarkable. I think there were quite a few others, too, that deserve credit. It was at the time of Lister Hill. He was a congressman who was able to push through support for hospitals, rural hospitals . . . the Hill-Burton [Act], I think?

CAC: Correct.

PQ: . . . Lister Hill. His dad must have wanted him to be doctor naming him Lister . . . who discovered antiseptics.

CAC: [laughter]

PQ: The climate then was, we can do anything in the United States and Minnesota has had that attitude.

CAC: There was a lot of money for everything. The NIMH [National Institute of Mental Health] is established just about this time, isn't it . . . in 1962, 1963?

PQ: Yes.

CAC: Or expands . . . it was there earlier but expands. There was a lot of money for lots of things in the early 1960s.

PQ: Lots and lots. I remember as a young faculty member, a visitor from the NIH came to see if we could use some of the money he had. His name was Mr. Silver and I thought that was so appropriate. [laughter] We found uses for that. My first research grant, actually, was not from the NIH. It was from Playtex Park. I always said, "I got my support from Playtex." And it was true that my very first personal grant was from Playtex Park. They were getting into the medical research industry. [laughter] Minnesota, in those days, was absolutely a ferment of excitement in research.

CAC: That's the context you came into?

PQ: That's the context I came in, back from the navy in 1957, as chief resident. I was able to stay as a research fellow in infectious diseases. When you think of that date . . . 1958 was when I finished my chief residency, coming back from the navy and spending a year. I had an opportunity to work with a man, Lewis Wannamaker, Professor Wannamaker . . .

CAC: Yes.

PQ: . . . who had come here from Cleveland, where he had been involved with the work at Fort Warren Air Force Base, establishing that rheumatic fever could be prevented by treatment of Group A streptococci with penicillin. It was led by a wonderful hero in medicine, Charlie Rammelkamp from Cleveland but Lewis was his right hand man; and he came here as a young faculty member in pediatrics. When I was an intern, he and I . . .

CAC: You were about age peers or was he a bit older?

PQ: We were about age peers but he was about eight years ahead of me medically because he went to medical school . . .

CAC: He didn't milk cows?

PQ: No, that's right. [laughter] We were the same age but he didn't milk . . . He had not only finished medical school in just a short number of years; but, he'd also accomplished this research had already won the [Albert and Mary] Lasker Award . . . Rammelkamp and these guys had gotten the Lasker Award, which is usually the stepping stone to the Nobel Prize in medicine, for their work with streptococci and rheumatic fever.

CAC: Now, the polio vaccine is just a little bit before this?

PQ: It's just a little bit after that.

CAC: After?

PQ: Yes. I think the discoveries were made in Boston with [Thomas H.] Weller and [John F.] Enders just before; but it was applied then by [Jonas E.] Salk and [Albert B.] Sabin just a little bit after.

CAC: These things are breaking loose scientifically about the same time?

PQ: About the same time. You're right, Clarke, in about 1957 is when the polio vaccine was being applied, and studied, and coming into its fore. We were in the midst of a polio epidemic in Minneapolis when I interned. My first day as an intern, I did ten spinal taps and two of those patients died.

CAC: Oh. my, oh my!

PQ: Four were in an iron lung. Kaboom! it was just a terrifically, amazingly, difficult time for everybody. Then, quickly, when I came back from the navy in 1957, the vaccine was being studied here. In fact, Maurice DeSilva—I think was his name—a South American, an Argentinean, worked with the people in our School of Public Health, involved in the Sabin oral polio vaccine when I was chief resident.

CAC: As an historian, I have sometimes speculated about the larger political cultural climate of the 1960s drawing upon the taking of a pill or having a shot . . . they are quick fixes . . .

PQ: That's right.

CAC: . . . from a lay point of view. Then, you get in the early 1960s, the birth control pill.

PQ: Yes.

CAC: *The* pill. I just wonder if part of the optimism of the 1960s, generally that all problems can be solved, doesn't gather some strength at least from those medical breakthroughs that occur late 1950s, early 1960s.

PQ: I think so, Clarke. I've thought about that so often. You know, it started with the atomic bomb on Hiroshima. All of a sudden, this enormous war that the whole country gathered its strength for . . . kaboom! it stopped with a shot!

CAC: An enormous trust in science.

PQ: Science could do that . . . kaboom! we stopped polio. We did. Then, again, penicillin could stop the fever, stop the earache.

CAC: Oh!

PQ: Everything is really a quick fix. The AIDS [Acquired Immune Deficiency Syndrome] now has brought us back to what's usual, in terms of doing something about a terrible problem . . . how slow it really is. When you think of smallpox being eradicated from the globe . . . terrific optimism there, but then that took 200 years. The AIDS . . .

CAC: Tuberculosis is coming back now but wasn't that pretty well quieted about the same time?

PQ: Right, streptomycin and isoniazid, kaboom! we could stop that. It was a heady time to be in medicine.

CAC: Oh boy!

PQ: Minnesota—I don't know if it's typical Minnesota fashion or not . . . I say that all the time and I really feel it—we were there and we saw the opportunity and we took it! This is pediatrics. It's documented in surgery.

CAC: How many pediatricians were there on staff at the university then?

PQ: I suppose about twenty-five, twenty, or so. We had a business meeting . . .

CAC: You all did combined research and clinical?

PQ: We all did combined research and clinical, right. A few years later, we started having Ph.D.s as part of the clinical faculty. That was new. Owen Wangensteen, in Surgery, and Maurice Visscher, in Physiology, had established a model for the collaboration between a basic science department and a clinical department; so, all of the surgical residents spent time in the Physiology laboratory, the disciplined basic science Physiology. We talk about the Minnesota clinical Ph.D. program. We were the only medical school where you could get a Ph.D. and you could sign your name M.D., Ph.D. Other medical schools had that but you'd get that degree in the basic sciences. In Minnesota, you could have a Ph.D. in surgery, a Ph.D. in medicine, and a Ph.D. in pediatrics.

CAC: That was instituted earlier or was this part of this breakaway you're talking about?

PQ: I think it was just about that same time, as I understand it. That's something to ask others about, Clarke.

CAC: Okay.

PQ: I think it was kind of an important Minnesota phenomenon. Owen Wangensteen insisted on the Ph.D. for all surgical residents; so, everybody in surgery had to take time in a basic science laboratory. They had to get their language requirements when they got their Ph.D., before they could stay on the faculty.

CAC: That prolonged this by a year or two?

PQ: Oh, sometimes as long as five years. Some of the surgical residents were residents for ten years; but then they were academicians when they finished.

CAC: That's a long apprenticeship.

PQ: Yes. I was never tempted to do that for some reason. I think it was because I was older and had all those kids by that time. The career in medicine has been a credit, I think, to the Minnesota environment. My personal medical career has been a credit to the Minnesota environment and the role models that I had in all departments of the Medical School, in particular, my mentor, Lewis Wannamaker, who was a scientist and a compassionate fellow. Although, a pediatrician had the discipline of a basic scientist, he was anything but a dilettante. I think the temptation in clinical research is to be a dilettante and not do anything very thoroughly. You can kind of publish papers and it's so rewarding immediately to care for patients—I'm talking about your own personal ego—and people thinking you're wonderful, that the research is so delayed. It's almost paradoxical that you could enjoy both. It takes a mentor, I think, in order to keep you . . .

CAC: Mentoring is of crucial importance . . . so are the signals that a large institution, such as the Health Sciences were and are, as a another ingredient. It's a matter of socializing beyond a mentor. You were lucky to have Lewis Wannamaker but we're talking about many more persons.

PQ: Yes, yes, yes.

CAC: My question is what kind of leadership, what kind of socialization . . . how many basic departments are there? Fifteen, eighteen? It's a big deal.

PQ: It's a big deal. Yes.

CAC: Were there leaders higher up, that is, deans and vice-presidents, or whatever, who would help to establish that culture?

PQ: I think, Clarke, I'd have to be honest and say that deans would have very little to do with it. That's kind of my impression. It's the luck of the chair of the department, the luck of the selection of a chair. Maybe, deans had something to do with it.

CAC: Well, deans select chairs.

PQ: Deans select chairs . . . they do; so, I bow to that. At Minnesota, I think it was the department chairs. Dean [Harold] Diehl was the pivotal dean in establishing the Medical School as a front runner in American medical schools. He had the vision but he was also a very gentle supportive person. He allowed these amazingly strong department heads to have their rein and do what they could do.

CAC: So, the model is a strong department? This is the province that matters in the Medical School the last thirty, forty years?

PQ: I think so, Clarke.

CAC: These are more heads than chairs in that sense? They had tenure in the position?

PQ: Yes, yes. They're powerful.

CAC: They can guide research and they can hire?

PQ: Yes. They really are quite powerful. They were powerful behind the scenes, it seems, in the early 1950s and 1960s. Then, they were powerful as visible, clinical chiefs in most of my career here, running their departments with a lot of autonomy.

CAC: In your case, John Anderson?

PQ: In my case, John Anderson, right.

CAC: Say something about him because he is more than a legendary figure, I know.

PQ: Yes. He was just a wonderful person. He was a pediatrician through and through, kind and thoughtful, a scientist and a visionary. He kind of established the Department of Pediatrics here in his own image. I think he could be said to be exceedingly permissive. In other words, if he had confidence in his faculty person, he let that faculty person develop as they will. That is, primarily, positive; but, there are also some negative sides to that. It worked in pediatrics. We all respected John. John A., he was known affectionately as by all the faculty. Dr. Anderson

was always Dr. Anderson to his face but John A. in any discussion. [laughter] We loved him. He allowed us great freedom.

CAC: It would not necessarily be a model, however, that would exist in Surgery, for example, where there's another kind of leadership?

PQ: It might not as much; although, somewhat the same atmosphere prevailed in Surgery. Wangensteen himself was much more of a hands-on administrator, I think. You'll have to learn more about that. John A. was not a hands-on administrator. He made sure that we, as a department, got what we needed. He went out for federal funds when they became available and we built laboratories and the funding for our salaries was there. He did things in his own way. I'll never forget when we could have our own private practice in the early years. Some of us got to see more patients and less patients. I went off to the Rockefeller Institute for a couple of years, 1962 to 1964, and really learned a great deal more about being an investigator there. Before I left in 1962, I was moving toward caring for faculty children in a private practice and being able to keep the money that was gained in fees at that time.

CAC: That went into the departmental budget?

PQ: No, it went into my own budget.

CAC: I see.

PQ: Dr. Anderson then, in about 1964 . . .

CAC: Unless monitored, that would have real problems.

PQ: Oh, yes. That, of course, was the climate at the university at that time. You had your secretary send the bills and collected the money. Each department in the late 1950s, early 1960s, decided themselves how they were going to handle this. Dr. Anderson established a committee and had me as the chair . . . what shall we do about the private practice aspect of Pediatrics? There were a number of us that met and we decided that we should leave it as it is, just kind of we collect our own fees. Dr. Anderson, the very next day after he got that report, established that the department would collect the fees from then on. That's how we operated. He knew what he wanted to do all along. He just had us kind of go through the motions. The next day after he decided, it became obvious that was the way to do it, that was the right way. So, then, we establish the practice. He thought we could raise about $80,000 a year but I think the first year, it was about $200,000.

CAC: But that went into the . . .

PQ: The department.

CAC: I see. It no longer went into the individual but into the department?

PQ: Right.

CAC: Those were funds generally available for personnel, for research, for . . .

PQ: And for salary increment. For most of my career, it's been that way.

CAC: Now, did the other departments operate . . . do they make the same decision?

PQ: Yes, they kind of went through the same, in different degrees . . . the same sort of change in the 1960s, then, of department collection. In other medical schools, they had a central collection system for the private practice fees but at Minnesota it was always departmental.

CAC: And remains down to the present day that way?

PQ: Until very recently. Now, the whole thing has changed in its structure. It's much more of a system with the hospital and the faculty combined, the University of Minnesota Health System; so, just in the last few months, it's come back to a much more centralized monitored sort of . . .

CAC: That arose because of the difficulties in some of the departments the last four or five years?

PQ: Right, yes. That's all changed very recently. Those early years . . . that's part of the permissiveness.

CAC: So, from 1960 to 1990, the system you're describing prevailed generally?

PQ: Yes, I think so . . . maybe, closer to 1968 or so until 1990, yes. It was a whole change in American medicine during that same period of time where I think we changed from a profession where the income generally was similar to other professors in the university and professions at large to one where there was almost a guarantee that you'd make a lot of money. It changed the nature of our profession quite a bit.

CAC: And the collegiality of . . .

PQ: I think so. I think it changed.

CAC: Can you say a bit more about that?

PQ: I'm not so sure that I know what I'm talking about, truthfully, Clarke. I can't talk about this with any of my colleagues. Nobody else agrees with me. I think there's a sense that we're entitled to all of this money because we have a long apprenticeship . . .

CAC: Sure.

PQ: . . . and this is our due. It's interesting that it's a very touchy subject. I, personally, feel that the United States is an aberration as far as physician, medical doctor, incomes are concerned. I think in most other countries, it's like it was when I started, that we were not so dissimilar from the professors in a university. Now, it's kind of an enormous difference, in my mind.

CAC: I'm guessing this must have made an enormous difference in salary structure from one department to another, from Surgery at the top to Proctology at the bottom, let us say.

PQ: [laughter] Yes, Pediatrics is actually at the bottom.

CAC: Oh, yes?

PQ: Yes, really, we are. I don't know why . . . little people, I suppose, little salary.

CAC: [laughter] Wouldn't this make for a hierarchy of income as well as a hierarchy of status?

PQ: Oh, it's enormous, yes. It's a hierarchy within the department. For example, cardiologists make quite a bit more and the [unclear], than the infectious disease. The thing that came with Medicare, and Medicaid, and the rest—and why I'll never understand—is a procedure could bring in a huge fee while talking to a patient is pretty modest.

CAC: Sure.

PQ: We don't have a procedure in infectious diseases . . .

CAC: But that doesn't bear on the elegance of the organ that is the focus of the speciality? I think of the brain and the heart as being pretty elegant organs.

PQ: Yes, exactly. And the eye. There are huge fees that can be . . . The other thing that happened, Clarke, I think—you've got to take this with a bit of a grain of salt—is that some of these procedures were worth the fee when they were established because they were difficult, experimental, enormous tension involved. Then, they became established and they were kind of routine but the fees never changed; so, you get $10,000 for a procedure that probably was worth it that took six or eight hours, tremendous stress and strain but when you do several of them a day, it's still $10,000 for the fee; so that seems a little bit self-serving. That's how medicine developed with the federal programs and that's changing now. That's what's so traumatic but it definitely has to change. Health care reform requires some difference in the fee structure and

how this thing is related. Your question is absolutely right on. There's a huge difference in income depending on the speciality that you're talking about.

CAC: Does this have any bearing on morale of faculty, generally?

PQ: I can't say that it does because for me, it does not. It doesn't at all because I love doing what I'm doing. My main argument was, "Gee, those of us who have got something going and love what we're doing in the lab, let us be in the lab." Yes. It's never affected my morale a bit. I'm a curious fellow so I kind of know what everybody makes. I really do.

CAC: You were chair of your department for a long time?

PQ: No, I've never been chair of my department.

CAC: I'm sorry. Okay.

PQ: No. John Anderson was chair all the time until he retired. Then, we've had two chairs since but I've never been chair.

CAC: I'm not going to belabor this a long time but talking with . . . I've had forty-two interviews now from thirty-six different departments or programs; so, I'm really scattered. People in the languages for example, far across Washington Avenue, the great Grand Canyon, have a feeling, you see, even within the college, that economists get a great deal more salary for doing less work than they do. Then, there's always looking across that chasm to the Medical School or to the Law School where we know that the salaries are higher. Not often is this empirically based. This is just a sense of hierarchy. It does contribute not always to low morale because many people like what they're doing but it does lead to a kind of skepticism about structures of rewards in the university generally.

PQ: I think so. I think so, yes. I think one of the aspects that comes up frequently is the research activities of the Health Sciences compared to the rest of the university and this—quote—overhead—unquote—that's part of the NIH support.

CAC: Overhead of 30 percent to 40 percent?

PQ: Yes, it's 45 percent.

CAC: How much of that roughly is captured by Central Administration and how much of it is retained in the Health Sciences?

PQ: I've heard different percentages but it has accounted for considerable resentment on the part of the Health Sciences, I think . . . the amount that is retained by Central Administration and to my understanding, even the support from the state legislature is dependent on the overhead. But

I don't quite understand how that formulation comes about. We feel that more of it should be returned for what it's intended, which is the overhead for the research. I understand that Central Administration feels that they require what they have, partially, for the tenure aspects of those of us who are primarily involved in research; so, there are lots of reasons for it. Everybody has misperceptions, I think.

CAC: I think very widespread.

PQ: Stanford [University], I think, got in the first trouble on a national scale of using that overhead money inappropriately and now the John Dingles of the world are looking at how overhead money is used at all universities. What I was trying to say to begin with, and kind of got to rambling on, is that we feel that the Health Sciences, at least, and the Medical School primarily, account for 50 percent of the research dollar that comes in to the University of Minnesota over all and that enormous overhead, say millions and millions of dollars, so, that of that 45 percent, there are millions and millions of overhead. We, then, are contributing to the University of Minnesota and, yet, we feel sort of isolated over here. I sense that that's our own doing, in some ways. There is that sense that we should get a lot more credit, sort of like Uncle Sam and the world, I suppose. That's a little bit of our . . .

CAC: It's important to have for the record. We're the largest, probably, state university in the country and it's a big sprawling university with many diverse interests, and styles, and so forth.

PQ: Right.

CAC: While we're on this research, let me ask a dumb question that lay persons occasionally come to; that is, to what degree does the availability of funding distort a basic research project? We make jokes about it, you know . . . it's the disease of the year, or of the decade, or something. How does funding, if not distort, give a green light or a flashing amber to various kinds of research? Do you have to guess what's going to be . . .?

[End of Tape 1, Side 1]

[Tape 1, Side 2]

PQ: . . . example, which is very immediate and it involves me, that part of my responsibility in the Pediatric Department was the directing of a training grant in infectious diseases for young people who wanted to have a career in infectious diseases. They were in the laboratory doing research. The NIH supported that training grant. I was the principal investigator and it was the National Institute of Allergy and Infectious Diseases. We were funded for ten years and had a wonderful record as far as young people training, and becoming assistant professors, and having their own laboratories. We were not funded after ten years because we were not involved in AIDS research in our training grant. One way is to just deplore that AIDS is getting all the money. What we did is change our emphasis to infectious diseases and developmental

immunology, which involved studies on the newborn and we applied to the National Institute of Child Health and Human Development and we were funded; so, we have funding now for another five years for training. We're training in infectious diseases but our emphasis is on developmental immunology. My colleagues in other institutions, have changed their emphasis; so, theirs is infectious diseases with AIDS as their infectious disease emphasis because the money is in AIDS research. My own feeling about that is that in medical sciences, the unknowns are so broad and so basic that if you have a good investigator asking questions with curiosity and collegiality, that you're learning something that's applied, that's going to be applied you know not where; so, I feel okay about it but you definitely do move the trough to where the spout happens to be that year. I offend people by using the farm analogy of maneuvering the trough to the spout but that's exactly what we do.

CAC: Particularly, when we hear so much in an election year of pork, right?

PQ: [laughter] That's true. I'd better change that and use another way of putting it. But that's definitely the case. It may have some shortcomings but I think there are some positive affects as well.

CAC: Would it be logical to move on and talk now about different managerial styles as you've observed them with deans, vice-presidents, chairs, directors, whatever? It may be anecdotal but history has got to have anecdotes.

PQ: It's so interesting that when I came to work here, Dean Diehl was still the hero as far as the dean of the Medical School, the director of the Medical School. It was his quiet leadership, and congeniality, and ability to get people to work together that he got high marks for. He was, then, followed by Bob Howard. Bob Howard is a terrifically intelligent person with a great sense of humor and ability to get along with people but he took his job with a great deal of conscientiousness. He wanted to do something about the private practice aspect of the Medical School and get a little more oversight and structure to this thing. Well, the powerful department heads were still here. That was probably a consequence of Dean Diehl's permissiveness, and congeniality, and supportiveness. Somehow Bob Howard's—I'll just put it the way I feel—inability to sit down and come to a consensus with these people . . . a more confrontative outcome was to his detriment or to his peril. He resigned, I don't think feeling awfully good about this school. I don't think it was very good for the school for the practice system, the way it had been established, to prevail.

CAC: Some departments were moving in the direction that you were speaking of earlier of having the proceeds go to the department rather than to the individual?

PQ: Right.

CAC: Dean Howard was hoping to accelerate that trend or to concentrate at the dean's level? Do you know which?

PQ: The sense in the faculty was that he concentrated at the dean's level.

CAC: I see. So, he was, implicitly at least, subverting in some degree the autonomy of these strong department heads?

PQ: Yes, anyway it was perceived that way.

CAC: Do you have any sense of how it was perceived, his relationships, across Washington Avenue with President [O. Meredith] Wilson?

PQ: I do not. I don't have any idea about that, Clarke.

CAC: Sometimes, a strong president or drifting president can provide support for a dean who is doing unpopular things.

PQ: I don't know.

CAC: I'll try that elsewhere.

PQ: We brought back a genial, wonderful dean, Neil Gault, who kind of allowed things to operate as Dean Diehl had allowed them to operate. I think that Neil grew up in the Diehl era. We continued to expand and Neil was able to keep the balance really well, I think, in terms of patient care, and research, and the emphasis on the medical students' education. The recruitments and all were effective. I'm not at all sure that the department head appointments after those powerful department heads resigned . . . They all resigned at the same time in the mid 1960s, Wangensteen, Visscher . . .

CAC: Which is a chance of age [unclear], right?

PQ: Just a chance, yes . . . [Donald] McQuarrie . . .

CAC: You've mentioned several who were university figures as well, at least Maurice Visscher was well-known by the university community, which a lot of these folks are not, were not?

PQ: Arnold Lazzero, I think, was well-known also in Anatomy and, then, Wally Armstrong in Biochemistry. They were university citizens. I don't think the appointments that were made after the mid 1960s . . . that was not necessarily a change in the university, it was kind of a change in the medical profession. There was much more of a separate . . . that's my perception.

CAC: This would be true here and elsewhere, in other schools?

PQ: Oh, yes.

CAC: So, there really is a drawing away of the Health Sciences from the larger enterprise?

PQ: Right.

CAC: This is a national trend?

PQ: Yes. In most places, they are separated geographically, Clarke; so, we really should be closer than we are. We're kind of more like we're geographically separate.

CAC: The impulse was that of the focus and concentration on research and clinical practice as opposed to what the larger mission of the university was?

PQ: Yes, I think so.

CAC: That's an interesting . . . and this happened many places?

PQ: Oh, yes.

CAC: At the same time?

PQ: Yes, it did.

CAC: It's the availability of lots of money and lots of funding that at least feeds it?

PQ: I think so.

CAC: It's not the cause?

PQ: Of course, Clarke, many medical schools were so separate anyway . . .

CAC: Yes.

PQ: . . . and they never had the collegiality or the university structure in the beginning.

CAC: I'm going to come later to your own . . . you were a university citizen. You mention Lazzero and you mention Visscher . . . these are names . . . I'm guessing the last fifteen years it would be difficult to find those [unclear]?

PQ: I think so. I think they tend to be—this sounds a little harsh—less influential people in the Medical School. I have to be careful there. I include myself in that regard because as I said, I was never the head of a department; so, I do include myself. There are a couple. Mike Steffes, who is in Laboratory Medicine and Pathology has been active in the Faculty Consultative Committee. David Hamilton was the vice-chair. He is head of what we used to call Anatomy.

Then, Amos Deinhart has been active in some of the university judicial committees; so, there has been some. For our size, it should be much more than it is. I think Marty Dworkin in the Department of Microbiology has also been active. But, it's not as it should be. I've been a voice crying in the wilderness but I haven't cried very loud.

CAC: Are there councils within the Health Sciences? Do you have elected assemblies? Do you send representatives from the departments to a college-wide governing body of any sort?

PQ: I don't think so.

CAC: I see. So, that, again, you're talking about <u>extraordinary</u> autonomy in the departments.

PQ: Right, right. There are such things as the Medical Staff Council, and there are things such as the Executive Faculty, and I think there's an administrative board; so, these things probably do happen but those of us that are rank and file members of departments don't feel them or don't . . .

CAC: Even if you carry the authority of a Regents' professorship?

PQ: Yes, right. [laughter] I don't feel I'm in the loop at all in that kind of a structure. No.

CAC: That's interesting.

PQ: I have wonderful loops that I am part of but not that, the governance of the Medical School. No.

CAC: Are there other deans or vice-presidents whom you would like to comment on?

PQ: Yes. I would like to comment on the structure of the Medicine Department around here during the time we're talking about. Cecil Watson was just a national figure. He was a big person in medicine and very distinguished. He's kind of your quintessential chairman of the Department of Internal Medicine in the Medical School. We called him "Stainless Steel" because of the Dick Tracy character who was always perfect. [laughter]

CAC: [laughter]

PQ: That was Cecil, C.J. Watson. He ran a department that the Medical School was extremely proud of. A number of people in that department were national figures. When he retired, there was a search committee and a colleague of mine actually, a little younger, from Yale, came out . . . Thomas Ferris . . . and became chairman of the Department of Medicine.

CAC: When you say Department of Medicine, that is Internal Medicine?

PQ: That's Internal Medicine, right.

CAC: I'm going to ask another dumb lay person's question having posterity that's dumber than I am in mind. We think of internal medicine as being as close to general practice or as primary care as there is within specialities. Is this an accurate perception?

PQ: Yes. The way that works . . . I think they called them Internal Medicine to separate it from the Dermatology.

CAC: So, it's everything inside the skin?

PQ: Yes. It's internal medicine after you're sixteen years of age. It's pediatrics before that. A pediatrician and an internist have pretty much the same background.

CAC: As distinguished from the other specialties that we could name, cardiology and . . . ?

PQ: Under the heading of Pediatrics, we have the subspecialties, Cardiology, Neurology, Infectious Diseases, and Hematology. Under the heading of Internal Medicine we have the specialties of Cardiology, Neurology, Infectious Diseases, Renal Diseases. That's the overall department of this Internal Medicine or Pediatrics. Within in that department are the divisions. We call them divisions; so, it's a Pediatric Division of Infectious Diseases . . . Internal Medicine Division of Cardiology and that sort of thing. That's another change.

CAC: When one thinks of primary care, which is a word much used for the last four or five years . . .

PQ: Then, you'd talk about a general internist. You have to use the term general or an internist. The academic Internal Medicine faculty tend to be subspecialists. Tom himself was a nephrologist, a kidney specialist. Most of us in academic are subspecialists within the department.

CAC: Would that have been true in the same degree forty, fifty years ago?

PQ: I don't think so, no.

CAC: So, the subspecialization has become more fragmented over this period?

PQ: Yes, right. Absolutely.

CAC: That's because of the nature of the human animal and of research monies?

PQ: Right, exactly. As a consequence, Clarke, we've developed loyalties to our national organizations in the subspecialties. For example—just an example really . . . it's not bragging

really—I was just enormously pleased and proud to receive the Bristol Award from the Infectious Diseases Society of America this year. That's their highest award given to a person's contributions over a career to the field of infectious diseases. I couldn't image anything nicer than to have my own subspecialty honor me in that way. Now, a bigger honor still would be a pediatric . . . the Howland Award. It's the pediatric honor for the pediatrician. I think many of us have sacrificed our stature as a pediatrician for our emphasis on the subspecialty activities within the area of pediatrics. That's not to say a cardiologist or an infectious disease person wouldn't also be a Howland Award winner . . . they are.

CAC: You found this a great personal award but, if I catch the tone, not widely recognized by one's colleagues.

PQ: That's right. I can hardly tell it to anybody because, oh, infectious diseases, what's that? [laughter]

CAC: [laughter]

PQ: But, among your peers, it's terrific. That's just an example, a little example, of how the subspecialties have become a major factor in a medical school faculty member's reward system.

CAC: Yes. As you describe this . . . existing at Minnesota but elsewhere as well?

PQ: Oh, yes.

CAC: This is not a Minnesota [unclear]?

PQ: No, no. It's interesting, Clarke, that it just happened in the 1970s in Oxford and Cambridge; so, the English pediatrics allowed medicine to subspecialize but pediatrics remained a general pediatrics program where a pediatrician was everything.

CAC: You know what my next question is going to be. If this is the culture and the structure of medical schools generally in this country, then, how on earth does a school of medicine ever train general practitioners?

PQ: Minnesota is a phenomenon again. We not only are the leading research medical school in the country—one of the leading anyway and in this part of the country, the leading research medical school—but we also turn out a higher percentage of family practitioners and primary care physicians than any of the others.

CAC: Is there a program in family practice?

PQ: Yes, a large program.

CAC: It has what kind of standing and what kind of research can they possibly do? It seems to me this is a practice orientation which would make that specialty, so to speak, very unusual in the whole family of departments.

PQ: Yes, it's true and it is. It's been grafted on. It's like grafting on another leg.

CAC: What are the rewards of an advance student going into family practice, primary care?

PQ: Oh, I think it's the stimulation that they've had in their experience caring for patients, to be able to work with an entire family or work with a person over a . . .

CAC: But the financial rewards are unlikely to be there?

PQ: No, but in our system of medicine now, they are pretty good. They may not be like some of the surgical specialities but they are really quite good.

CAC: What kind of persons are hired to staff a program in Family Practice? Is that the right term or what do you call it?

PQ: Oh, yes. The Department of Family Practice and Community Medicine is what ours happens to be called.

CAC: That staff is what kinds of folks as distinguished from the specialists that you're describing elsewhere in the college?

PQ: I don't know how to answer that actually. Initially, when it was grafted on to our Medical School, I remember those discussions. We had a general internist head the department of Family Practice. He was the head of the new Department of Family Practice. It took awhile for Family Practice to become accepted in these high-powered subspecialty departments. He was able to bring that about. Then, the medical, political climate needed a family practitioner per se; so, it was a person, I think, in practice who was very successful in practice, respected in his community, and had some evidence of being a good teacher for medical students that was brought in. Those are the faculty that have headed the Family Practice. There's been a very strong attempt to establish some sort of clinical research in the Department of Family Practice.

CAC: What would the nature of that clinical research be?

PQ: Oh, I don't know. I can't answer that. It's been difficult to have the kind of research that goes on where you have a bench and you have all the facilities that we do; so, I think it's responsive patients to some epidemiology or hypertension and response to medications, that sort of thing.

CAC: The furor within Health Sciences and health delivery systems generally in the last five to eight years was evidenced in the ruckus nationally this last year. I found the debate more confusing than enlightening . . . I tried hard. What we hear frequently there and from the [President Bill] Clinton Administration is this term *managed care*. From the inside, what does that say to a school of medicine, a college of medicine and persons like yourself?

PQ: Personally, I'm affected as a patient by now having a gatekeeper. That word gatekeeper is new in the lexicon.

CAC: But you use it. Medical people use it.

PQ: Yes. It was imposed on us by the managed care people, I think.

CAC: How do you perceive that in your relationship to the insurance companies and so forth? We can't talk about the larger global issue but from the point of view of an academic person like yourself?

PQ: I sit and read the editorials in the *New England Journal of Medicine* about managed care and its effect on the academic health centers; so, I have the feeling that my response is more theoretical than real but in my own response, I feel that we could practice in the best of all worlds if it was managed care in the best sense of the word. Like the gatekeeper is a person . . . That's the term that's used and it's kind of imposed I think by a CEO [chief executive officer] or probably by a lawyer. My general internist, I see him about a problem, a hernia for example, he examined me and he said, "Yes, I think you ought to have that fixed." Now, if it wasn't a hernia, or big enough, or in the history, it hadn't bothered me, he'd say, "No, you don't have to have [unclear]. You go ahead on your own." I kind of wish he'd said that, as a matter of fact. I just had mine fixed a week ago and it still twinges. [laughter] But he said, "Yes, you ought to have that fixed." So, I went up to see the surgeon, brought all the proper paper and the surgeon said, "Ah, I see you've been referred so it will be all right under the state health plan." So, he fixed my hernia, and I go on my way, and that works just fine. That's my one personal example that happened this week. Now, I would think that you could practice medicine just wonderfully in that system. I personally think so.

CAC: But the gatekeeper may often be an insurance person and not trained in medicine.

PQ: Yes, that would be terrible; but the guidelines can be established by physicians and people who are knowledgeable about medicine. The outcomes can be evaluated by physicians, those who are knowledgeable about medicine. Those young people laboring in the vineyard of medicine can do it without much thought about fees or their own incomes; they know what that's going to be. I think the Mayo Clinic has operated this way for years.

CAC: Yes.

PQ: The group health that's developed enormously has operated this way. The [Northern California] Kaiser Permanente [Medical Care Program] has operated this way and the system in Norway has operated this way. I was six weeks as a visiting professor in Bergen last year.

CAC: Do you folks in departmental meetings talk about this?

PQ: Never. Never.

CAC: When you go to the Campus Club for lunch?

PQ: I wouldn't dare mention it outside these walls to my colleagues in practice.

CAC: Why?

PQ: They would yell at me, and they would talk about how terrible it's going to be, and how the Canadians are so unhappy.

CAC: I see.

PQ: I don't like controversy; so, I love to be able to say it to you. You're the only person, outside of my wife, that I have dared say how I feel to.

CAC: Just think, there are going to be 10,000 people listening to this tape.

PQ: [laughter] And that's okay because they won't be able to yell at me. [laughter]

CAC: [laughter] Another recent development, and you played a part in that yourself I gather, was in developing a program—I don't know what to call it—in biomedical ethics, very recently. Say something about that because you were on the committee.

PQ: Right, I will. That is a credit to our medical students. That would be a wonderful way to wind up this interview.

CAC: Oh, no, no, no. We've got some more things yet.

PQ: Have we?

[break in the interview]

PQ: I give credit to the medical students at the University of Minnesota Medical School for that. The students felt the need for more experience and guidance in biomedical ethics. They established a noon conference in the early 1980s on biomedical ethics.

CAC: Heavens.

PQ: They invited people to speak. Then, they convinced the dean and Neal Vanselow, then our vice-president for Health Sciences, to develop a biomedical ethics curriculum and a program. It was Neal, then, with the students and some faculty representatives who put together a proposal. They included the people in Sociology, and Dentistry, and the Philosophy Department to go to the Northwest Area Foundation for support. The Northwest Area Foundation in their wisdom came through with $300,000 to get this established . . . $100,000 to be spent each year. They asked me, then, to be the interim director of the program . . .

CAC: Good.

PQ: . . . with the possibility of being the director but just kind of getting it started. It was at that point in my life when I stopped being chief of staff of the University Hospital. I'd been chief of staff for five years. That's being kind of like a grandfather and responsible for credentialing of the staff and really part of that hospital. I loved those five years, actually, continuing my research, being in Pediatrics, and being involved as chief of staff, like a grandfather is because I wasn't responsible for the budget of the departments. When I stopped that, then, this opportunity to be interim . . .

CAC: I'm going to interrupt . . . What is a chief of staff then? I thought it was a really high-powered administrative position.

PQ: No! No.

CAC: So, what are your portfolios?

PQ: The chief of staff is really the member of the medical staff who is responsible for the activities of the physicians involved in patient care. To do that, you have a wonderful structure of committees, the most important of which is the Credentials Committee. The Credentials Committee reviews the qualifications and reviews the physician's ability as a doctor, as a physician and passes muster. They pass the person as credentialed or not . . . he or she. Then, there are all kinds, the Pharmacy Committee . . . just dozens of committees that are involved.

CAC: You could make that a full time job?

PQ: You could make it an absolutely full time job. It requires several assistants. I think a *New Yorker* cartoon summed up best how I operate as an administrator. There is this guy sitting in a perfectly empty room in an easy chair. The only thing in the room is this guy in the chair. The caption was, "I manage to delegate everything." [laughter]

CAC: [laughter]

PQ: That's how I manage. There's nothing much to show for those five years except the new hospital.

CAC: That's a pretty big show.

PQ: It was an absolutely peaceful five years. I must say that I can think of a few things where I headed off what could so easily have been a confrontation but they were not because we had a structure.

CAC: What kind of confrontations are likely to arise?

PQ: It would be a department chairman trying to fire inappropriately one of his faculty members or it could be a department that was calling the other department kind of malpractice or terrible things, accusations, kind of the way human beings act with each other. It would come to the chief of staff.

CAC: A situation like the ALG [Antilymphocyte Globulin] would come before the chief of staff?

PQ: Probably not. [sigh]

CAC: Where would that be monitored?

PQ: That should have been monitored by Central Administration, we say.

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

PQ: By the vice-president for Health Sciences as part of Central Administration.

CAC: Okay. Why was it not?

PQ: Why was it not is a wonderful question. I think that part of it has to be because the right hand didn't know what the left was doing and they felt that the FDA [Food and Drug Administration] regulation and everything was being met. I think that was probably because the director of the program [Richard] Condie influenced John Najarian that everything was okay . . . not to worry. Then, John, who was busy with everything else . . . you'd think that he would have been clinically suspicious that things weren't all that great but he wasn't—or it didn't work anyway. Then, the Central Administration figured if big John says it's okay, it must be okay. So, it was just a lack of oversight or the system, the process, wasn't there for oversight. We have a wonderful process of oversight as far as clinical practice is concerned. So, it's the application of ALG that would have come in . . .

CAC: I see.

PQ: . . . that was inappropriate; but the financial structure of the ALG program and all of that would never have come to the chief of staff.

CAC: I was going to suggest that it's not only a lack of systemic monitoring but a culture of deference.

PQ: It is. It is. It is. Yes. Yes, it really is. It's like the story . . .

CAC: Which is not to fault it unduly because a little deference is all right.

PQ: . . . of when somebody got into heaven, and they saw this fellow with a cap on, and he's wearing a mask and had it hanging around his neck—you know this whole story—and wearing the scrubs, and things over his shoes. Someone said, "Who is that? Is that a surgeon?" Someone else said, "No, no, no. That's God. He just thinks he's the chief of surgery." [laughter]

CAC: [laughter] Let's drift back to biomedical ethics, which is where we were.

PQ: Yes. It gave me a chance to be the interim director of the Center for Biomedical Ethics. I've said to everyone that it's the medical students that were the energy behind that. Then, Neal Vanselow himself felt it was terribly important. We found there were pockets of medical ethics or bio-ethics going on all around this place.

CAC: Yes, you mentioned Sociology and Philosophy. Who in those places were . . . ?

PQ: John Dolan in the Philosophy Department was very interested and Gene Mason was interested. Dolan was the most active in the biomedical aspects of it. I think it was a sort of a thinly disguised Right to Life activity; but, at any rate, John was very active and he had his own motivations for it. Five years from now, I don't know how that's going to sound. That's just one person's perception. Mason was terrific.

CAC: Then, you hired this [Art] Kaplan?

PQ: Kaplan came.

CAC: Maybe, it was that program that hired him?

PQ: Yes, that's right.

CAC: Were there more core staff, so to speak, or did you borrow your staff?

PQ: We had a nurse, Dianne Bartels, who took some further training in leadership at the Hubert Humphrey Institute and had had some experience; so, she was the associate director. Then, I had

a wonderful student, Tim Culbert, who did a lot of the leg work; so, that was our program as we got started. The Board of Governors of that Biomedical Ethics Center were the deans of all the schools: the Law School, the Hubert Humphrey, the CLA [College of Liberal Arts], the Medical School, and the other Health Science schools. We met with them once a year. Then, we were able to operate pretty much . . . establishing curriculum, and having programs in Biomedical Ethics, and participating in the hospital Biomedical Ethics programs. Then, Art came in like a whirlwind.

CAC: Did he come from medicine himself?

PQ: No, he's an interesting person. He has his Ph.D. in philosophy, an enormously bright person and capable of expanded activities in the academy, as you put it. So, he at Columbia University had attended medical school with the medical students, especially those third and fourth years. He really was with the medical students in the clinical programs at Columbia at the College of Physicians and Surgeons there, Columbia Presbyterian. When he came here, he had absorbed kind of the mystique of the physician, genuinely absorbed it, and he also had the credentials of a philosopher. His Ph.D. is in philosophy. Then his own bright mind and his willingness to go out on a limb . . . and, yet, the amazing ability to discuss this highly charged sensitive subjects without polarizing. He had a phenomenal capacity. He really established and Dianne continued to be his associate director. She's very good as a nurse . . . is her background and a very stable, steady person. Then, they developed a nice staff of secretaries; so, it really expanded and developed when Art came.

CAC: This would be a difficult position to replace now that he's gone?

PQ: I think so. I think it's going to be very difficult.

CAC: There aren't many persons like this.

PQ: There are not many persons like Art Kaplan. There are a few. There's a Hastings Center for Biomedical Ethics, which is kind of the breeding ground or stable of these people. Art himself was second in command there. Dan Callahan is the director. We were fortunate to have Art. I said something in one of the alumni magazines, "I'm most proud of the fact that we were able to develop a Biomedical Ethics Center that could attract someone of the calibre of Art Kaplan." I really meant it. Now, Art has a place up in [unclear] and I hope we can do the same. There's a strong search in the process.

CAC: I'm going to switch gears just a little bit and ask you about the quality and the kind of students that are attracted to medical schools as it might have changed over the thirty, thirty-five years in your experience.

PQ: I think that's a wonderful question, Clarke. I'm not sure I'm going to give you an answer that means very much. I think that the kind of students that are attracted to medicine are

genuinely compassionate people who are interested in being able to somehow contribute to the well-being of their fellow citizens. They have a role model or they have a sense that the medical profession or being a physician is somehow a chance for them to be of genuine service to people. Maybe that sounds too grandiose and too . . .

CAC: This would have been a consistent description from 1960 to 1990?

PQ: I think so. I don't think it's changed very much.

CAC: More women, however, have come into the profession.

PQ: Yes. This is a natural profession for women and I think women have had this sense for a long time; but I think they've hit too many barriers along the way early on. What happens in my class is there were 10 percent women and that was pretty standard. Ten percent women was the medical school class all around the country in 1949 when I started. I don't know why they got the 10 percent.

CAC: [unclear] just kind of a fallout?

PQ: There was never a quota. No one would ever admit to a quota but that was sort of a fallout. This business of having a variety of people had sort of changed. They had to establish . . . there's always been something like that because when the job market for Ph.D.s fell out, you could have filled your medical school with Ph.D.s for awhile.

CAC: I see.

PQ: So, you can't really just say blankly, "We just take the best qualified or the most highly degreed." There's always had to be kind of a selection process, which is kind of complex actually. At Minnesota, for years, we've had what we called a PI, which is a predictor index. That takes the persons's GPA [Grade Point Average]—there's a little factor where you went whether is was Carleton, or Harvard, or Concordia, Augustana—and then the person's science grade and non-science grades. That all went into the calculator and you came out with a PI. If you PI was too low, no one ever looked at your application.

CAC: Isn't there something like the LSATs [Law School Admission Test] for medical practice?

PQ: Then there's the MCAT, the Medical College Aptitude Test. That goes into the formula, too.

CAC: Which of these indicators is the more positive, I mean the more . . . ?

PQ: Nobody knows. Nobody has any idea how many of those people with their PI below the number that was looked at would have made absolutely phenomenal doctors. I have a feeling

that I'm one of them, not that I'm a phenomenal doctor. I don't think that my PI was probably high enough to even be considered when I think of my MCAT scores and grades. I just was accepted at Yale before the MCAT . . .

CAC: There's no screening by a personal statement, for example?

PQ: A big personal statement, and interviews, and then review of the portfolio by the Admissions Committee if you reach that PI, predictor index number. That's how it works.

CAC: You say 10 percent in 1960 were female. In 1970?

PQ: In 1970, they were probably up more to like 20 percent of 30 percent.

CAC: And 1990?

PQ: Fifty percent.

CAC: So, the medical student body here would be half and half, roughly?

PQ: In Duluth there, it was a little bit more women last year.

CAC: Minorities of color?

PQ: The diversity factor is really remarkable at Duluth where they put in an affirmative Native American program. They have fourteen Native American students in Duluth now and they have only fifty students or forty-eight students in each class. There were recruits. They have a marvelous program. We've had an Affirmative Action program here but we do not have, I don't think, as many Blacks as we did a few years ago where it was more aggressive. We have Spanish American, Hispanic. There was something in the paper recently about the diversity that we have accomplished but it's not where it was.

CAC: When the percentage goes from 10 to 50 percent of female, does this change the nature of the program at all? Students sometimes make a difference in the kinds of education provided.

PQ: I don't think that has, Clarke. I think the adversity at the University of Minnesota Medical School has made a difference, the adversity of the problems that we've had in terms of ALG . . .

CAC: I see, recently.

PQ: . . . and then the child psychiatrist with the fraud in research and a number of adverse publicity things. I think it's made the faculty pull together more in an interesting paradoxical sort of way. The medical students this past two years have praised more enthusiastically the nature

of their experience as medical students than they ever have before. It's interesting. They feel that they've been well-instructed and well-treated. They are just coming away with a wonderfully positive feeling about how they've been treated. There were a few years there where they felt that they were sort of an encumbrance on all of us as we went about our research and patient care; so, I think there has been a renewal of our zeal toward paying attention and doing what we should be doing as far as for medical students.

CAC: Almost every basic discipline department in the country gets reviewed and, then, layered out, the top ten, the top twenty, and so forth. Is this true of medical schools?

PQ: It is, yes.

CAC: Has there been any change in the position . . . this is really a reputational measurement and very subjective. That being the case, where has Minnesota been over the last thirty, forty years?

PQ: I think it was just a shining light in the 1950s. It was considered right up there with the top ten, I would say in the 1960s, 1970s, and 1980s. I think it's probably in the top twenty now, lower part of the top twenty. I don't know . . . that's just so subjective.

CAC: It would be the perception of these difficulties that have come in the Health Sciences that would lower the . . . ?

PQ: I think so, right. I think the research advances or the dramatic things that have happened in terms of the research . . . a lot of it is based on that. A lot of that in the 1970s and 1980s was the open heart surgery and, then, the wonderful discoveries in immunology that I participated in myself, and Bob Goode, and others, and Wannamaker in Microbiology. There have been still wonderful things; but, I think we're more like a run-of-the-mill school now, in terms of the publications that come from our research activities.

CAC: You attribute that relative decline to what factors?

PQ: I don't know, Clarke. I can't tell.

CAC: Could you say something about the school at Duluth? When did that come into existence?

PQ: Probably twenty years ago, twenty-five years ago, thereabouts.

CAC: It's not a campus with a widespread distinction in all departments who would contribute to a Health Science, to put it in those terms; so, how did it happen that one would think of having two schools—plus the Mayo?

PQ: I think a prime motivation was producing more physicians for rural Minnesota and family practice, primary care. I think there was just a . . .

[End of Tape 1, Side 2]

[Tape 2, Side 1]

CAC: . . . put up a School of Social Work there with the same kind of thought that it would have a rural and kind of hands-on . . .

PQ: Was it successful? The Medical School has been very successful. They're very proud of the number and percentage of students that actually are practicing in rural communities. Now, with their Native American program, they're terribly proud.

CAC: It must have been difficult to staff from scratch and start up a medical school?

PQ: In those days, there were a number of new medical school starting. There was a bunch of them that started around the country, about thirty medical schools. An awful lot of states started a second medical school. There was this tremendous sense that we were going to have a shortage of physicians. In typical fashion, of course they overproduced. There's an estimate that you could close all of the medical schools for five years and probably end up with about the right amount of doctors twenty years from now. [laughter] I'm not so sure if that's right.

CAC: Say something about the relationship of the University of Minnesota to the Mayo [Clinic].

PQ: Yes, that was interesting. When we started out this interview, [I said] I grew up in southern Minnesota and it was an absolute fact that whenever we were just a little bit sick we'd see the local doc in Faribault but when there was something my folks were really worried about, they'd go to the Clinic. The Mayo Clinic has always been an enormously important component of my whole life. The University of Minnesota and the Mayo Clinic had a relationship for a number of years when I started here where we were the graduate degree granting institution. The Mayo residents got their degrees actually from the University of Minnesota. There was this sort of scholarly association, quite separate and some rivalry but a separate relationship. Then, the Medical School was discussed for <u>years</u> before it was started down there; so, we knew there would be a Mayo Medical School. There was concern here that it would be a competition for the state dollar for support of the medical schools but that I don't think ever came to be. They established an endowment sufficient so that it's a totally private school.

CAC: Is it financed in any part by patient fees or not?

PQ: I don't think so. I think they were able to establish a separate endowment. I heard a figure that the income from that endowment for each medical student would make them <u>totally</u> independent as they operated that medical school . . . in the sense that their faculty are the

practicing physicians in the Mayo Clinic beyond the basic sciences, the clinical faculty; so, the students themselves have a wonderful clinical experience down there.

CAC: So really, Minnesota has three schools with slightly different missions. Duluth is substantially different.

PQ: Yes.

CAC: I suppose I should interview someone up in Duluth on that in my second round.

PQ: I would think so.

CAC: I can't do it this fall.

PQ: Ron Franks is their dean. He's a psychiatrist. He came here from Colorado. He's a wonderful person. He's a very, very good person.

CAC: Okay. You've done other things as well. You were chair of the ROTC [Reserve Officers Training Corps] Relationships University Committee in what I would take to be pretty delicate years, the late 1960s and early 1970s. Say something about that.

PQ: That I think was my first experience as a part of the university community, responsibilities outside of the Medical School. I suppose it was Arnold Lazzero who was the chairman of the Anatomy Department here, who was a university citizen, who encourage me to participate and I did. I suppose I signed one of those university Senate Consultative Committee of what you're interested in and why I put ROTC, I'll never know. But I became a member of the committee for a couple of years and, then, they asked me if I would be the chair. Lo and behold! that's when the 1960s really started coming to Minnesota and the student uprising. An attempt to stop . . . when they presented the flag . . . to have the guard carry guns, that was one of the most amazing things. Again, it was just a matter of bringing the university together with the ROTC. We always had students on our committee. While I was head of that thing, I was so pleased, because things could be so adversarial but they would sort of end up with an understanding. We compromised, I remember, on the gun issue by . . . I've forgotten . . . there were guns; but, it was less offensive somehow. [laughter] There was a little compromise.

CAC: You compromised so that the guns would not accompany the flag?

PQ: Yes, there were guns but I've forgotten how that all happened. It somehow was able to happen. It was a member of your department, who of course was the hero in all of that.

CAC: Tell me about that. Rodney Loehr?

PQ: No, it was a fellow historian . . .

CAC: Harold Deutsch?

PQ: Harold Deutsch.

CAC: All right. What did he do?

PQ: He had great sympathy for the military.

CAC: Oh, yes.

PQ: His history of the military was a popular course and his credentials as an academician were impeccable.

CAC: Yes.

PQ: He gave credence . . . It was a delicate balance between the military outlook on the life and the academy's outlook on life and Harold Deutsch could span both of them.

CAC: He was a member of the committee?

PQ: He was a member of the committee.

CAC: I see.

PQ: Oh, yes, he certainly was. It worked. For some reason, that gave me a great deal of confidence that I could work with people that I didn't know and that weren't physicians. I went off on sabbatical in England and that's when I stopped being a part of that committee. I enjoyed that.

CAC: I think you served on the Faculty Consultative Committee at one time or another?

PQ: Yes.

CAC: Say something about that.

PQ: That was such an interesting experience for me. I never felt that I was a contributor. I guess I felt I contributed on the ROTC committee. I felt I was an observer and I understood better how the university operated. That was the time when Peter Magrath was the president and Nils Hasselmo was the vice-president for Planning, is the way I thought of it. Ken Keller was the Academic Affairs V.P. [vice-president]. Those three were kind of a triumvirate that met with us. That was the administration that met with us and I got this sense that there was remarkable quality in the administrative part of our university at that time. I was so impressed with Nils and his ability to discuss things that were going to influence the future, the components and what

their consequences were . . . on almost any subject. Ken, of course, whatever subject . . . his calculator mind was always right there and usable. The relationships were wonderful between the faculty and the administration at that time. Peter himself was sort of quick tempered about things but he was quick as well; so, it was impressive to me.

CAC: Would you say that there were major issues that the committee itself influenced as faculty persons . . . if there's a balance of initiative and authority? Vice-presidents and presidents, obviously, carry authority with them but what was the impact, do you think, of the faculty group?

PQ: I thought that the faculty group had an influence and asked questions that were appropriate. Virginia Gray was one of the members of the committee at that time. There were strong women. Shirley Clark was involved and another person, whose name I can't bring to mind. The questions that were asked were good ones. The only issue I remember, I guess, involved the Health Sciences—I think John Turner was involved—and that was if, when Lyle French retired, they should continue with the position of a Health Sciences vice-president. That came up for debate on the Senate floor. I was involved with that in some ways. I got the sense that the faculty views were heard and articulated; but, I never felt that I was totally in the loop?

CAC: But you don't know how much ice it cut?

PQ: No, I don't know how much ice it cut, nor do I have any sense that I <u>really</u> understood what was going on, truthfully, Clarke. [laughter]

CAC: Modesty is becoming. How long have you done the TV program out of here?

PQ: We're starting our eighth year, Clarke.

CAC: Eighth year!

PQ: Since 1987.

CAC: How did you get into that?

PQ: That was kind of interesting. I was sitting in my office or the lab in the other building at that time and I got a call from the dean's office. They said, "The dean wants to see you." I said, "Oh, what's that about?" They said, "We can't tell you." I said, "Oh, oh, something is amiss." I come to the dean's office and it's Sally Howard and David Brown. I didn't know this till afterwards but it was Sally that had decided that I'd be a good person to host a program about health. She had convinced Dave Brown that I would be a person who would be able to do this, I suppose with some modesty and grace, or something, I don't know what else because I don't know that much about medicine outside of my own specialty. It was Dave who said that they were thinking of establishing a new program on television. It was going to be patterned after something that was going on in Duluth called *House Calls*. It was a call in program that would

be on the university television activities in Rarig Hall. Would I consider being the host of that program? I said, "Sure, I'll try that." Sally was kind of dumbfounded. They had prepared, I guess, about a half an hour of reasons to convince me to do that. [laughter] I was sort of like the chief of staff or the interim director of the Biomedical Ethics Center. That's sort of my character. I'll do things to do them . . . and sometimes to my peril. This one worked out okay. [laughter] We watched one of the programs that they'd had in Duluth, a video. Then, we went over there, and the format is that the medical students answer the phone and, then, we're in a separate room with a host and three guests on whatever topic. We don't have to listen to the callers but they bring the questions in; so, it's a live program.

CAC: This means you have to know people in special fields . . .

PQ: Yes, right.

CAC: . . . who are not only informed but can talk to a lay audience? Are there a lot of folks like that? Do you have good luck finding . . .

PQ: Oh, yes. Everybody loves to be on.

CAC: But are they *good* at it?

PQ: Most of them are, yes. Most of them are unbelievably good at it. I think I have something to do with that because I kind of put people at their ease and it's very low pressure.

CAC: Yes, it's a very low pressure program.

PQ: They want me to speed it up and there were attempts to try to make me better but what they see is what they get.

CAC: What kind of response is there?

PQ: It's kind of interesting in that each time they do sort of a poor man's Nielsen [Rating]. They figure there's about 7,000 to 10,000 households that have at least dialed it in. I don't think they've ever asked how many people watch the whole program because it does move along sort of slowly. I enjoy it. It turns out I enjoy it immensely because I get to know my fellow faculty members that I wouldn't have a chance to sit down and talk to.

CAC: You draw on doctors outside the [unclear]?

PQ: Those that are outside and I have a feeling it's a little bit of a healing town/gown, too, because I always have somebody outside. Sally Howard is the secret of success because she is so full of vim and vigor. She's the head of the Health Sciences public relations. Her staff does all of the secretarial, the letter writing.

CAC: How do you decide what disease or what issue you're going to take up in a given week?

PQ: Three times a year, we sit down with an anonymous committee and we go through the topics and we go through guests. I'm part of that. I've been around so long that I know most of the people here and then people have suggestions.

CAC: Even though they're anonymous.

PQ: [laughter]

CAC: But they aren't anonymous to you?

PQ: No. [laughter] It really works. That's how we decide and, then, have a list of possible guests. Then Sally's office gets to work and calls.

CAC: How many do you do a year?

PQ: We start in late September and we end in early June; so, we do . . . We skip Christmas. We do it every week on Tuesday night. It's the only <u>live</u> program that they do. The cameras are run by graduate students.

CAC: But you're often traveling?

PQ: I've arranged it so I don't travel on Tuesday nights. I get back Tuesday afternoon or I leave Wednesday. Then, when I am gone—I'm going to be in Hong Kong in February and early March—the dean has filled in for me and Bill Jacott in the vice-president's office, who had been in Duluth, fills in. Now, there are a couple of other people who fill in for me when I'm gone.

CAC: That's a good response.

PQ: I think so.

CAC: I think that a lot of people are very concerned . . . I think particularly now that patients are better informed themselves and more responsible for their own health.

PQ: I like it because the calls are genuine calls. I kind of relate to the caller; so, the answers are at the caller's level of understanding. Another index of the viewership is that we have a brochure, either from the Association of Neurology, or something prepared by the nurses here or the physicians and they get about 200 calls for those brochures after the program.

CAC: I see.

PQ: That gives a little indication of . . . and it's low budget! We're all total volunteers. I volunteer. The guests volunteer. We get free parking.

CAC: Bravo.

PQ: Then, there's also some crackers and cheese there. The graduate students run the cameras and they love it because it's live.

CAC: Of course.

PQ: Yes.

CAC: This might lead to a question logically of the relationship of the Medical School to the medical community beyond the academy. I'm sure you've had experience with that not only raising money but in general matters of practice. Can you say something about that or is that too big a question?

PQ: Oh, Clarke. No, it's right on. It's a very important question. The people listening to this in years down the pike . . . It's really kind of sad that there is as much town/gown rivalry or lack of understanding as there is. I feel sad about it because I kind of watched it develop during my entire career here where there's been kind of separatism that's developed. I think a lot of it is our own fault. I think during those glory days of research, that we talked about in the 1960s and the 1970s, we became insular. I mentioned my own chief, John Anderson, and I mentioned Tom Ferris, and I mentioned John Najarian . . . all three are wonderful people and in terms of the academy, I think, they've done a terrific job. Yet, in terms of being able to understand and be receptive to the community of practicing physicians, sufficient attention has not been paid. I fault the Pediatrics Department and myself as much as anybody for this because I've been complacent and gone about and done my own work. I feel like I come out and look around like a ground hog about once a year. The fact is that we've been insular. The people who have graduated from our school and that we've trained as subspecialists haven't felt much of a family orientation. The one exception is Dermatology where there's a beautiful relationship between the town and the gown.

CAC: How do you account for that?

PQ: It's small. They've had compassionate directors of their department. Peter Lynch is the son of a former head of the department who is in practice. His dad was my dermatologist when I was growing up. It's been much more of a family. There's some reason it's worked okay. But in other departments, it's just not been that way, including Pediatrics. They built the Minneapolis Children's Hospital, which was needed; but, it was decided that we should pretend it wasn't there or not be supportive. Then, it got to be adversarial and rivalry. That's healing now; I think it's gradually healing. Surgery . . . you remember John decided that they shouldn't do heart transplants at Abbott Northwestern. They resented that and brought in this guy from Utah; so,

they do heart transplants over there. Then, in Medicine, Tom had a real enormously important standards of excellence for everybody in that department. That was his real goal, and he's maintained that, and it's been wonderful; but, there's been a rift in the practice.

CAC: But not many of you, then, in the academy are active in the Minnesota Medical Association, for example?

PQ: I am. I was just past president of the Minnesota Academy of Medicine and that, by its very structure, has a third of its membership from the academy, a third from St. Paul, and a third from Minneapolis. That's one kind of social club where we have talks every month.

CAC: That's not the AMA [American Medical Association] in Minnesota?

PQ: No, that's not the Minnesota Medical Association. Quite a few members of our faculty are not members. I happen to be a member. I became a member when I was chief of staff; but, I've not been active in it at all. That's the story of most faculty. We're not active.

CAC: What is the relationship to the medical insurance companies in the state?

PQ: I don't know that very well.

CAC: Do you serve, for example, Blue Cross Blue Shield, Group Health, etcetera . . . do members of the faculty serve on those?

PQ: I don't think so, no. No, we don't. We're not active in the governance of medicine in the state.

CAC: We've covered a large number of topics, my friend.

PQ: We have. It's been fun, Clarke.

CAC: Always, at this point, when I seem to be running out and I think you're kind of reaching a . . .

PQ: Yes.

CAC: Are there any other final reflective comments of a general order that you would like to make?

PQ: [laughter] Oh, gosh, I don't think so. We've covered so many things. I'm so glad you asked about the medical students because they are a shining light. I told them when I talked to the parents of the freshmen class last Saturday that I consider myself as one of the <u>blessed</u> people for being able to spend my <u>entire</u> career doing what I've been doing and being surrounded by

medical students. They are wonderful youngsters who are altruistic and our main job is to not spoil them. I think that Minnesota has done a pretty good. We can be proud of that.

CAC: That's a good positive note to conclude on. I thank you very much.

[End of Tape 2, Side 1]

[End of the Interview]

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