

# Legacy of Learning: A Founder Reflects

*Abstract: Park Nicollet Health Services is an institution steeped in tradition. In 1921, the first multispecialty clinic, Nicollet Clinic, was formed in Minneapolis. Its founding physicians included some of the most respected professors of medicine at the University of Minnesota. Thirty years later, 11 young doctors opened a small but progressive clinic—the St. Louis Park Medical Center. In August 1983, the 2 institutions merged, and Park Nicollet Medical Center was formed. Remaining true to the mission of its parent organizations, Park Nicollet based its practice on the values of excellent patient care, continuing research and education, and service to patients and the community. Arne Anderson, a well-respected pediatrician, now retired, was one of St. Louis Park Medical Center's founders. What follows is an abridged version of solicited material that Dr. Anderson submitted to the Institute. His sentiments are emblematic of the passion that the Park Nicollet's founders exuded—as they forged a new path toward comprehensive, innovative health care in Minnesota.*

—by Arnold Anderson, MD  
Cofounder, St. Louis Park Medical Center

From the beginning, the founders of St. Louis Park Medical Center were a spirited group of individuals with threads of shared passion. We had spent our formative years of adolescence in the culture of the Great Depression. We were veteran physicians of World War II, completing our post-war residency training. We were all married, and our wives were as dedicated to the success of our clinic as we were. For almost 2 years before the clinic opened, we worked together to create its facilities and the organization. I suspect—from knowing the interests and capabilities of my cofounders—that most of us had been recruited for academic positions. But we passed them up. We all had a keen desire to practice in the private sector because we believed it could provide the environment for service that would best fulfill our career dreams.

Although private practice was our style of choice, no existing private practice that we knew of could have offered the kind of setting that we envisioned individually or collectively. We knew that we could not create our dream practice as individuals, but we believed that we could do so as a group. That mutual belief and interdependence certainly was part of the cohesive dynamics that caused the founders to persist in our mission and

overcome the obstacles and challenges we encountered.

## *The first lessons*

Just before I left my pediatric fellowship at the Mayo Clinic, my wife and I sold our home in Rochester to a physician who was the retired chairman of Mayo's urology department. He bought the house for his son, who was to be a new fellow there. I was so appreciative of his paying cash for the offering price that I informed him, "When I have complex urological problems in Minneapolis, I will be sure to refer these patients to your section at the Mayo Clinic."

The well-established specialist took the occasion to give me a lecture. "You will do nothing of the sort," he said—and proceeded to inform me of the importance to my patients and career that I not refer complex and difficult challenges to other physicians.

With that admonition, I did not refer my patients to other doctors when difficult cases arose. I soon sensed that my partners felt the same way about themselves and about each other. If we had a tough problem, we solved it ourselves; I regarded each of my partners as the ultimate authority in his specialty, and my colleagues had mutual expectations of me.

Our beginnings were humble. We didn't have a building and did not

practice as a group until July 1951, but we met regularly to plan our eventual practice together. In the meantime, our family moved to Minneapolis in June 1950 and I launched a practice on the back porch of an old duplex on the east end of Main Street in Hopkins. Cost for the facilities was \$50 a month. The furniture and equipment were either borrowed or unpainted. I answered the phone, did the lab and janitorial work, and waited for patients from 9 A.M. to 5 P.M. (Hospital rounds and home calls were made before 9 A.M. and after 5 P.M.) My wife, Rusk, kept the books and sent out the bills. Initially, this venture and our family living expenses were all financed by the other partners, each of whom contributed \$30 a month.

Early in my practice, I became aware of my partners' expectations of me. Don Freeman, an obstetric partner and an instructor at the University of Minnesota, had delivered a baby who was failing to thrive in the hospital, despite the efforts of pediatricians at the University. He requested a consultation. I considered neonatal sepsis, which was confirmed by a blood culture, and the baby enjoyed a cure with the appropriate antibiotic. The outcome so impressed the University pediatricians that I was asked to make weekly pediatric infectious disease rounds at the University. (In addition to my pre-war residency experience with infectious and contagious diseases, my fellowship at Mayo included a minor in pathology, so my experience with pediatric infectious diseases had been

substantial.) My early teaching with the University was invaluable—not only for the experience itself but also for what I learned regarding the capacity of this academic institution.

It is likely that all of the partners had equally significant opportunities during the years prior to the St. Louis Park Medical Center's opening. Still, we remained loyal to our passionate commitment to build a unique group practice in Minneapolis. While we had great mutual respect for our professional sophistication, we were very humble from an administrative perspective. Before the building was completed, we held our group meetings at the University's Campus Club, where we could have free space. There was never any food or refreshments at the meetings. Occasionally, we had a potluck supper for the group with our wives at one of the member's homes. There were never enough chairs, so most of us sat on the floor.

The fellows from the University had recruited the best nurses and technicians, so we had very competent pioneers in those fields. But there were so few! When we opened our building, there were 2 nurses—1 for obstetrics and pediatrics and 1 for all the surgical specialties, medicine, and the emergency room. We had 1 laboratory technician, 1 x-ray technician, and 1 office person, who served as receptionist, telephone operator, and bookkeeper.

To keep costs low, the physicians shared the janitorial chores and the responsibilities for maintaining the

building and grounds.

### ***Sharing resources and talent***

Our beginnings, while modest, were demonstrative of our commitment to patient care and the community. As a core mission of our practice, we strived to preserve the individual identities of the partners while sharing our resources and experience for the benefit of our patients. Here is just a sample of how this multidisciplinary collaboration worked:

### ***Radiology and laboratory diagnostics***

Sewell Gordon, our full-time radiologist, revealed himself to be an extremely talented diagnostician. We would bring our patients' x-rays from the hospital for Sewell to read, and he often made critical diagnoses. Because of my interest in infectious diseases, we bought an incubator and instituted a microbiology lab service. Wyman Jacobsen took charge of our lab and used the fast-developing technology for laboratory diagnosis of metabolic diseases.

The convenient, sophisticated radiology and lab services and available minor surgery, procedure, and emergency facilities—along with the creativity of the young founders—resulted in a spectrum of services heretofore unavailable in the local area. Some examples of these unique outpatient services were diagnostic lumbar punctures and spinal fluid analysis (very much needed during polio epidemics). The innovative environment provoked us to create

new techniques and equipment such as calibrating smears of sterile urine for culture counts, using glass and metal urethral catheters in female infants and girls, using urine cultures instead of urine leukocytes counts to diagnose urinary tract infections, and developing use of clean-catch urine techniques in girls. The radiology services provided us a very convenient means to do imaging of the urinary tract. As the result of the availability of these facilities, we documented the reliability of our new methods and the incidences of various conditions, especially infectious diseases in our community. With our outpatient bacteria services, for example, I was able to discover 2 new significant occurrences. The first was isolating the vector in a salmonella epidemic; the culprits were 50 newborn chicks that grocery stores had given to children as Easter presents. The second discovery was the entity of peri-anal streptococcus as the most common cause of the miserable and baffling diagnostic problem of pruritus ani in children. Our outpatient bacteriology also facilitated our recognition of a nosocomial newborn nursery staphylococci infection, resistant to antibiotics, which was spread by a nursery staff member.

In our x-ray department, procedures were introduced that were not commonly done on outpatients. I have already mentioned the urinary tract imaging. Adenoid imaging in infants, toddlers, and children was also of great help in documenting adenoid hypertrophy in cases of nasal

obstruction. As a reaction to the excessive practice of tonsillectomies and adenoidectomies and the discovery that tonsillectomy increased one's vulnerability to bulbar polio, adenoidectomy was akin to malpractice, especially in the academic centers such as the University of Minnesota and among some of the respected pediatricians in private practice. Consequently, an unusual number of children had developed sleep apnea, failure to thrive, even cor pulmonale caused by adenoid hyperplasia nasal obstruction. These children had been allowed to continue to suffer because of the belief that adenoid nasal obstruction didn't exist. Our simple outpatient x-ray evaluation on the size of the adenoids helped us provide indicated treatment that resulted in very gratified patients and parents.

Treatment of infantile hip dysplasia as a means to prevent congenital dislocation of the hips was just being recognized. Our available x-ray enabled us to quickly make a definitive diagnosis. Hip splints and accessories for children with hip dysplasia were not available, so we created our own designs and provided parents with the material to make the splints themselves. We also created designs for special highchairs and infant seats for those children, which could be made at home with a few tools and some plywood.

#### ***Pediatric cardiology***

At the same time as we were using our innovative diagnostic treatment

services, partner George Lund, MD, was developing a cardiac practice, employing a catheterization lab at Mount Sinai Hospital. Dr. Lund was the only available pediatric cardiologist in the private sector in the metropolitan area. The clinic also provided open heart surgery at Mount Sinai Hospital for the repair of congenital heart defects. This service really distinguished the clinic as being the ultimate in sophisticated services in the private sector.

#### ***Pediatric allergy***

When Norman Sterrie, MD, joined St. Louis Park Medical Center in 1953, he pioneered pediatric allergy as a subspecialty. There were no training sites in Minnesota, so Dr. Sterrie created his own curriculum by studying immunology at the laboratory of Robert Good, MD, at University of Minnesota and clinical allergy with an adult allergist in the private sector (who also taught at the University). Dr. Sterrie also created and directed the weekly pediatric clinic at the University and later at Hennepin County General Hospital. All the while, his pediatric allergy practice at the St. Louis Park Medical Center site was continuing to grow.

#### ***Behavioral pediatrics***

In addition to my interest in infectious diseases, I had a keen interest in what is now called behavioral pediatrics, by virtue of my training at the Mayo Child Development Institute during my 3 years in Rochester. As a result of the tremendous need for professionals in this field (primarily

because of school learning problems), I quickly developed a significant practice and outreach program in this area.

### ***Pediatric intensive care***

Another significant unique practice style we adopted was to provide intensive care for the critically ill child. Instead of referring critically ill children to the University of Minnesota or the Mayo Clinic, we took care of them ourselves—first at Mount Sinai and later at Methodist. To provide those children continuous adequate service, one of the pediatricians stayed full-time with the child at the hospital. This practice resulted in a relatively large referral practice from throughout the state, Northwestern Wisconsin the Dakotas, eastern Montana and occasionally Wyoming.

### ***Other pediatric partnerships***

After 5 years, it became apparent that if we were to meet the needs of our patients using state-of-the-art practice, we needed to expand our services not only in the number of pediatricians but also in the subspecialty areas.

In 1956, Dr. Richard Cushing joined us after finishing a residency at Yale. He subsequently took a 2-year sabbatical in allergy at the University of Michigan and came back from that to join Dr. Sterrie in the pediatric allergy practice. He created and founded with the Minnesota Respiratory Association a popular camp for children with asthma.

In 1957, Dr. Don Etwiler, who had been a colleague of Dr. Cushing at

Yale and who had gone on to complete a 1-year endocrinology fellowship at Cornell, joined us. Dr. Etwiler immediately took a responsibility at the University to provide services for children with diabetes. There he recognized the need for patient education; his efforts to meet that need resulted in the current International Diabetes Center.

Dr. Loren Vorlicky came about 1960. He has subspecialty training in oncology and went on to develop pediatric oncology services at Park Nicollet.

All of our new partners started with a general pediatric practice and quickly developed a subspecialty practice. They very quickly adapted to our practice style, which provided each patient with a personal pediatrician. They shared emergency call, made hospital rounds with the whole group 6 mornings a week, personally reviewed their patients' cultures and x-rays, engaged in clinical research and education, and created a unique community service.

### ***Battling backlash***

While patient satisfaction was growing, our practice in the private sector was very different from the legal and ethical standard of the day, often defined as "usual and customary practice." As a result, the medical community's reaction to the changes we brought were not always so positive.

Few colleagues had much good to say for us. They labeled us a group of "commies" and undoubtedly, in many

cases, local physicians chose not to refer patients to us, although we did have a good referral base among the local family practitioners, outstate and out-of-state-physicians. I dramatically sensed my peers' thoughts about us on 2 occasions. One time, when I was about to open the door to Fairview Southdale staff lounge, I heard a tremendous amount of unintelligible conversation. When I opened the door, there came a dead silence. Another time, while at Methodist, the lay chairman of the board of directors came to a monthly meeting of the medical staff to learn what the hospital could do to improve its services to patients. Naively believing the chairman was serious, I stood up in the meeting and identified a few critical needs of children that hospital services were not meeting. On my way out of the hospital, I was walking behind the tall, well-nourished, jovial chief of staff, who had his arm around the shoulders of the much smaller chairman of the board. I heard the chief of staff say, "You know, Arne is a nice guy, but he is a little nuts."

The first major negative peer criticism came from the Hennepin County Medical Society Board of Directors, when they published an official reprimand of us (as a group) in the county journal. The reason? We had sent a letter to patients to whom we had given the first of 2 scheduled polio shots; in the correspondence, we informed them that we would notify them by letter when the second polio shot was available. I didn't realize how many doctors read the minutes of

the Medical Society until the reprimand was published. Nobody I talked to could understand the logic of the reprimand, and some referring family practitioners even sent me personal presents with notes of condolences. About 2 weeks after the reprimand was published, a directive came out in the *Journal of the American Medical Association*, advising that doctors inform their patients regarding their second polio shot—just as we had done.

The medical society had what was called a grievance committee, where people could report physicians deviating from the “usual and customary” standards of practice. Throughout the years, we were tried repeatedly by this grievance committee.

One of our first complaints came from the State Pharmacy Board; their concerns were that we were not qualified to operate a bacteriology lab and that our treating  $\beta$  hemolytic streptococcal pharyngitis exclusively with parenteral prescriptions was not in the best interest of the patients. The second objection, of course, was related to our using penicillin, the drug of choice and not available in an oral form at that time for streptococcal infections. About 3 years later, the National Heart Association took out full-page ads in the newspapers, advising patients to have their children evaluated for strep infections and, if they had such an infection, to have them treated with penicillin. Doctors started doing patient throat cultures and making bacterial diagnosis of

throat infections. Our questionable practices became the approved standard.

Another complaint was so frequent I quit recognizing the grievance committee’s request after a time. It was instigated by welfare department social workers statewide, who claimed I was overcharging patients for evaluations of learning and behavior problems. When patients came to me with such a problem, I told them immediately that the fee would be at least \$50. Because these challenging children were usually involved with a county agency, the social workers told the parents the county welfare department would pay for my services, which they defined as a physical exam and which they priced at \$15. I informed them that my evaluation was much more than a physical exam and that the parents were happy to pay the fee. (I was practicing what is now called behavioral pediatrics.) My “overcharges,” nevertheless, were reported to the Medical Society.

I was called so often to appear before the committee that by 1960, I refused to go when called. In order to carry out the grievance’s committee’s responsibility, the executive secretary of the County Medical Society had breakfast with me periodically to receive my report about the complaints against us. The committee’s conclusion was always the same: that our practice wasn’t customary and usual but that the committee members didn’t feel justified in reprimanding us or trying

to change our practices.

The state insurance commissioner thought that he, too, should weigh in on how to practice the “customary and usual.” One of our patient’s family had bought one of the new health insurance policies known as catastrophic insurance. Shortly after the purchase of the policy, the patient had a fever and sore throat, and the father advised the mother not to have the child seen by a pediatrician because “she was running too often to the doctor with the children.” Two or 3 weeks later, the patient was hospitalized with rheumatic fever—most likely the result of the untreated streptococcal infection the boy had a few weeks prior to hospitalization. The counseling the father required was much more time-consuming than the care required for the boy. When the boy was discharged from the hospital, Dr. Lund sent the family a bill that included the father’s counseling services. The total bill was \$250, if my memory serves me right. The insurance company thought it was exorbitant, and they convinced the state insurance commissioner that he should bring legal action against us. The evidence was Dr. Lund’s fee for taking care of the situation, a fee that in their minds deviated from what they considered “usual and customary” for a week’s hospital care. The insurance commissioner wrote the patient’s father a 2-page letter on how the father was to cooperate with the insurance commissioner in bringing us to trial. The father sent the insurance commissioner’s letter to Dr. Lund,

who showed it to me. I called the then-state attorney general, Walter Mondale, and asked him if the function of the state insurance commission was to charter insurance companies or monitor physician's fees. Mr. Mondale requested that we not make an issue of the incident "because we already have too much trouble over here." That afternoon, an

officer of the insurance company was in our office with a certified check to pay the bill in full. He had chartered a plane from Milwaukee to be sure there was no delay in payment.

The doctors of our clinic developed policies for reactions to all these threats. To the medical society and their associates, we were highly cooperative, but we never changed our course regarding practice values. We attended medical society meetings and worked diligently on medical society and hospital committees. If a patient of another doctor called us for emergency service, we took care of the emergency and immediately called the patient's personal physician to determine how he wanted the patient's

follow-up care to be programmed. This attitude obviously paid off in time, given the way St. Louis Park Medical Center doctors were accepted and became leaders in organized medicine.

***Loyalty and unity: A foundation for success***

One of the features of the group was the loyalty the members had for each other. In spite of the financial and other problems we had during the first 10 years of practice, we remained true to the group's goals and style of practice. Only 1 member of the group left during that time, and he moved to Sioux Falls, South Dakota, to make it possible for a handicapped child to attend a special school there. Many members had

very attractive offers to practice elsewhere during those formative years.

Another "no holds barred" aspect of loyalty involved the partners' criticisms of each other, particularly during new case reviews. While critics, they were also faithful to our mission, and I know that I became a much more competent doctor because of those critical case reviews. Such

reviews were not practiced in other settings, such as hospitals, because the severe criticism would not be accepted as politically correct. We had a saying that our concern wasn't who spilled the milk but how the milk was spilled.

Early on, we had been advised by a wise retired physician that if we could maintain unity in the group, we eventually would be successful. Somehow, we sensed the importance of unity. Being a Quaker, I was familiar with decision-making by consensus. In fact, when I became chief executive officer in 1958, Bob Benjamin used to announce our monthly business meeting as "Arne's Quaker meeting." There were some very significant decisions early on, for which there was solid unity. Dick Weber at the time reminded us that decisions regarding time were more important than money—especially because we didn't have any money.

A major commitment was made to personal research and education because we all believed personal research and education were essential to the ongoing competence we expected of each other. This commitment led to the investment at least 10% of our time in what we called academic time—and more academic time was allocated for partners if it was deemed important and necessary. We did not consider expense-paid lectures and meetings as part of academic time, nor did we consider local government meetings and hospital responsibilities as academic time. The result was that

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our group members became active in organized medicine and served on local and state government commissions, national committees, ad hoc study groups, and consensus guideline groups. All of these national contacts were helpful in recruiting physicians and technicians.

As I remember it, we had consensus on all our major practices such as academic time, equal pay, and taking on new partners on an equal basis. There were discussions on these issues but in the end we all agreed on how we would proceed:

- I remember Dick Weber challenged our time spent doing clinical research. He proposed that if we gave the money intended to be invested in personal research to the University, the net result would be better for society as a whole. We agreed with him, but we also believed our personal research was essential for the development of new group practice.

- Another partner challenged our taking on new partners with a purchase of a clinic share based on book value rather than current appreciated value. We stuck to book value because we were very concerned about the negative affects on unity if new partners had to have a lesser financial share than the founders.

- The decision to create variable pay came about because one member whose participation we valued told us that he didn't want to work as hard as his partners. It wasn't with the hours of practice but the areas of research and education where he felt the

unbearable stress. As a result, we set up a variable pay system with 60% of the clinic's annual earnings and 40% into a bonus fund. The bonus fund included many performance areas, such as bookings, community service, research and education, clinic governance, hospital governance, and participation in professional organizations and programs.

- In the spirit of the institution-building that Dick Weber established, we followed a recruitment policy that challenged us to always recruit physicians who were better trained and more accomplished than we were. Another institution administrative practice that created unity and strengthened the institution was that every proposal and action was justified by our mission statement.

### *Honoring education and research*

It became obvious that for physicians to reach their potential in research and education, they needed an administrative and supportive infrastructure in that area. We recognized that the research and education administration required a different mindset than a professional service organization in the private sector. Another issue was that we were receiving significant donations from physicians, parents, and other physicians to whom we gave free service, and these donations required a tax-free recipient. For these reasons, we created the foundation.

The motivation for our individual and corporate pursuit in learning came from 3 sources, by my analysis. We

all grew up during the Great Depression, went to college and medical school, and interned before we went into the service during World War II, so we were of the generation that had a significant work ethic and discipline. Secondly, we undoubtedly experienced a selective process; there was great financial sacrifice to be part of the group's adventure in a search of a new dimension of excellence in the practice of medicine. Thirdly, for the first 10 years, the only way to survive professionally and financially as a group was by our vigorous search for excellence through learning. The duration and severity of this financial pressure was documented in June of 1957, when I was arranging to leave the group because our income couldn't support even our frugal lifestyle. Early in 1958, we had to cut the base pay by one-third in order for the institution to survive.

I have already mentioned the group's attitudes and investments in "academic time."

We also made an unusual large investment in a library which was unsurpassed by any other local group in private practice. We had a complete journal and textbook library for our multiple specialties.

We disciplined ourselves to maintain an ambitious schedule of journal reading and meeting attendance. I assume the other fellows had a schedule similar to my own. I read 3 pediatric specialty journals and the *Journal of the American Medical Association* each month. My colleagues in medicine read the *New*

*England Journal of Medicine* and the *Lancet*, and they kept us informed regarding articles in those publications. Bimonthly, I read the *European Journal of Child Development and Neurology* and annually, I read the abstracts of 2 pediatric research societies and the Society for Infectious Diseases and the *Yearbook of Pediatrics*. We each went to our annual subspecialty meetings and took turns attending the annual Academy of Pediatrics and the pediatric research society meetings. After each meeting, the person who attended gave a formal report of the meeting to our pediatric section. We also took every opportunity to give continuing medical education talks at county medical societies, at the University post-grad programs, and occasionally for a state program. We developed a database of clinical information on our chiefly outpatient practice, from which we did clinical reports in our clinic journal, the state journals, and occasionally a national peer review journal. As a result of our new technologies (for diagnosis of urinary tract infections and treatment of congenital hip dysplasia), our significant original observations of unrecognized disease vectors and previously unidentified symptom complexes, and our unique subspecialty practices in the private sector, we were invited to participate on national committees of the Academy of Pediatrics, the National Institutes of Health, and the Children's Bureau. We also participated on

consensus forums and developed clinical guidelines. These latter experiences were unusual in that we enjoyed intimate professional time with the national leaders in various fields. We disciplined ourselves to do 1 major presentation every year, such as a reporting on a research study in a medical journal or a textbook chapter, editing national manuals, or giving state and national presentations or a series of continuing medical-education talks on state programs.

We recognized that our articles and talks often failed to reveal any original or new concepts, but we felt this activity of organizing our thoughts on a subject made us much better informed regarding the subject—and much better practitioners. In other words, we believed that this speaking and publishing activity was a major factor in our personal and professional development. We also were very actively representing pediatrics in our local and state communities, giving PTA talks, making presentations at state educational and social work associations, serving on medical society committees and boards, being school and camp doctors, and serving on governors' and mayors' health and youth commissions. These activities provided us with (1) insights and understanding of our patients' school and social environment (2) contacts useful in advocating for individual patients, and (3) credibility for being child advocates.

By virtue of this disciplined study—and especially by taking advantage of

the research meetings and abstracts—we were able to provide diagnostic services comparable to those available at the Mayo Clinic and the University of Minnesota. Generally, we were able to provide a more personal service than those larger institutions. We also developed working relationships with physicians throughout the state, in Northeastern Wisconsin, and through the Dakotas to Eastern Montana. Our referral base was the market area of Minneapolis and St. Paul metropolitan area. When I took a leave of absence from the St. Louis Park Medical Center in 1967, 75% of the patients I hospitalized came from outside the metropolitan area.

### *Filling a void with vision*

For years, I have tried to identify the bond that held the group together—the ingredient that caused us all to work so hard and be so creative for such a relatively small compensation. One thought I had is that we individually wanted to practice a service-oriented rather than a research-directed style of medicine—yet practice with academic expectations and standards. Collectively, we created the St. Louis Park Medical Center because there was no other place, of which we were aware, where such a practice could exist. I believe that with hard work, creativity, and significant sacrifices in time and money, we succeeded in creating the services we had envisioned.

Now we call that vision an “evidence-based” clinical practice.

The founders were about 30 years ahead of their time, but their idea was one whose time had come.

I sense from my current conversations with my founding partners that our successors have done well in maintaining the principles of practice we envisioned. The current Park Nicollet staff members have obviously carried our visions far beyond our dreams.