INTERVIEW WITH ERIC LINCKE

MARQUETTE, MI

OCTOBER 20, 2010

SUBJECT: MHS Project

MAGNAGHI, M. RUSSELL (RMM): I can call you Eric?

LINCKE, ERIC (EL): Yeah.

RMM: Okay, my first question for all interviews is when is your birthday?

EL: February 26, 1932.

RMM: Could you give us a little of your background? Where you from Marquette? Were you from someplace else and came to Marquette?

EL: I'm an outsider. My birthplace and place of education was in western New York, Rochester, New York. I grew up there and spent my first 26 years there. I went through undergraduate school at the University of Rochester in premed and then went on to medical school at the University of Rochester, finishing up in 1957, and after that a trip to Hanover, New Hampshire, Dartmouth Medical Center, for an internship. The internship was a general internship. My interests at that time were in surgery. After an internship one looks for further training to go into whatever field he wishes, in this (my) case general surgery. General surgery [residency] is a 4 year affair. So, after 26 years in Rochester, going through undergraduate and medical school, it was a return to Rochester for 4 more years of general surgery residency with an affiliated hospital with the university system there. It was called Rochester General Hospital or the north side hospital. During that 4 years there was also a fellowship that I took in cancer surgery at Memorial Hospital in New York City. So, I had a good background and had completed everything by about the age of 30. At that time the military was hovering and they insisted that we commit ourselves to 2 years of service. This was just prior to the Cuban crisis (Cuban missle crisis) in the early 60's. The Cuban crisis came about roughly in 1964 but my early military experience, fortunately, was in an area that I had never been [to] before, the west coast, Whidbey Island. I was teaching surgery at a small naval institution and this was the first time….

RMM: Is that up in Washington?

EL: Washington State. It's near [the] Tacoma River. There were large cities in that area, beautiful, the straights area, Luanda fuci. My wife and I and three small kids went up there and

spent two glorious years as a surgeon for the hospital, also enjoying the upper Washington area. These two years were years of great experience at Whidbey Island and filled out my confidence as a surgeon because it was the first time I was able to be on my own, call my own shots, and do my own surgery. So after that period we began to look for a private practice opportunity.

RMM: So this is about what year?

EL: This was about 1964 roughly. I graduated from med school in 57 and [did] five years of residency and internship and then service [in the U.S. Navy for 2 years] and so that took us to 1964. At that time the appropriate thing to do for a young surgeon was to look for a practice and we had done a little bit of research as [in this] regard and we actually applied to a corporation that offered opportunities for surgeons. We had a group of listings that we planned to look at. We were going to drive right across the country from Whidbey Island to the east coast. We really didn't know where we wanted to settle, both of [being] easterners. My wife [was] from New Jersey and I am from New York so this was an opportunity that we found rather thrilling to embark on because it really meant the future. We have these four kids in a car and a U-Haul [trailer] so we started from Whidbey Island, we went down to Oregon first and there we found a clinic in Salem, which is the capital [of Oregon]. We thought, "Gee this is a nice place". They wanted a surgeon but they said in order for you to practice here you've got to have the Oregon state boards and I said, "Well, I've already passed national boards, I've got my medical certificate and so forth". They said, "That doesn't make any difference. You have to have this (medical license) in Oregon". And for that matter, we found out that these National Boards that we had were not adequate for practice in about a half dozen states, which was strange to me. The national boards of surgery are kind of the entry point for practicing medicine (actually this exam is required for board certification in surgery but not for a state medical license) anywhere in the states. There are a lot of states that have peculiarities and they insist on this type of thing (requiring an applicant for a medical license to pass their own state board examination). So we went down.... We took the Oregon state board [exams] and we passed those and we said, "This clinic is nice but we've decided to go across the country". And then we proceeded to go directly across the northern states. We weren't at all interested in the south, being mostly from the northeast and having relatives out there like [my] parents and her parents and so forth. So we stopped at….our first stop was in North Dakota. I take that back, Montana. We went to eastern Montana and saw a delightful opportunity there but again that seemed too isolated and too far away and what not. We added it to our agenda as a possibility. We went from there to Mandan, North Dakota and there we looked over a private practice but again it seemed sort of primitive and too far away from home etc..... From there we proceeded on to the Upper Peninsula of Michigan and neither one of us knew a thing about the Upper Peninsula of Michigan. We knew about Lower Michigan and auto plants and whatnot. We got up here and both of us immediately like the grace of the area and the geography because we were both outdoors people. We liked to camp and things like that. We went to, first of all, Crystal Falls where there was a possibility but [it was a] small hospital and not much opportunity. And we went to Marquette where Dr.

Mathew Bennett (he may be one of the people you're familiar with in talking to others) was looking for a partner and he was the original general surgeon in this area. That looked very attractive so we had a nice visit with him and we looked over the hospital and liked what we saw. So we put that on the top of our list. We weren't committed yet. We wanted to go all the way across. We specifically went back [to] western New York. We looked over the areas and then around Rochester because this is where I had spent most of my years and we loved Western New York. We looked over a few small communities but none of them appealed for one reason or another. Either the medical facilities weren't adequate or they already had surgeons and whatnot so that eliminated [them]. From there we proceeded to Vermont. We went to see a clinic in St. Johnsbury, Vermont. Having spent time at Dartmouth, as I mentioned, as an intern, we were interested in New England because their geography there is attractive in camping and mountaineering and so forth. That clinic appealed to us a great deal. So it narrowed the choices down to Marquette or St. Johnsbury. So we went back to Marquette and this Dr. Bennett (Matthew Cole Bennett, MD, general surgeon) was a very captivating personality, very dynamic and had a good standard of his practice. And we decided then and there that it would be a good partnership. There was one drawback, and that was: he had a partner by the name of Leo Lindquist (Leo Anselm Lindquist, MD, general surgeon) and he had had him [as a partner] for 4 or 5 years. And I had a chance to talk to him and he said, "You shouldn't come here to Marquette. They only need one surgeon, as the area is small and the economy is pretty poor". So he was the one that gave me a fairly negative feedback on it, but I don't know; we like the area a great deal. Our first impressions of Marquette though, I'll have to say, is that it wasn't very striking in 1964. As you approach the city on U.S. 41 the only thing they had was this building which was [a] broken down building that held the beer plant (brewery). You probably know that. There was no commercial development. Just a very antique appearing city. Having come from Rochester, which was very progressive, it was kind of a downswing. We did like the hospital and we did like the fact that there were several specialists in the area already and many of them you may know, [including] the Elzingas, Dr. Eugene Elzinga and his son, Dr. Don Elzinga, Sr., who did some of the original polio rehabilitative surgery here in town. I had a chance to talk with him. And there was a man who was an ENT specialist, Kronschnabel, and he again gave me a fairly good profile. But the two who really influenced my decision, other than Dr. Bennett, were Rochesterian's. One was Dr. Bolitho (T. Boyd Bolitho, MD) who was a radiologist. I'm not sure he's been mentioned to you but he trained in the same hospital I did in Rochester and he was able to give me a comparative evaluation of the two cities and what merits this particular community of Marquette would have over Rochester. And Fred Sabin [Frederick C. Sabin, MD, ophthalmologist (1924-1997)]. Fred was also a New York person. I think he'd come from Syracuse and linked up with Dr. Hornbogen (Daniel Powell Hornbogen, MD) who was one of the original ophthalmologists here. These were very key interviews that I had and were the things that influenced us to finally lay down our roots. The first thing we did was to rent a little house over on West Park Street and we started practice with Dr. Bennett and that proved to be very fruitful. The guy was a tremendous person to work with. A very dynamic surgeon, very helpful in getting me to know the community well and we were inseparable in terms of taking charge of very difficult surgical problems. Just as an anecdote: my first weekend on call here (we alternated weekends and he and I were the only ones covering the area), a ski

mishap came into the emergency room. And this was New Year's Eve and it turned out that the young man who was injured over here at Marquette Mountain, he'd fallen on a ski pole which impaled his abdomen and he was in profound shock and near death. And I thought, "Oh my gosh, this is a start". I had never even had this in my experiences as a trainee. I went and saw him and I called Dr. Bennett and Dr. Bennett said, "Well, I've got you in reserve (inaudible)". I can see what you're up against because the one problem surgeons have is they do need good assistants when they're doing their work, particularly general surgeons. He came over and we operated on the young man and we saved his life. He had a torn vena cava and we repaired it and did some other things and that kind of kicked off my experience. Because I found within the first year that I was here, that the variety of surgery is so incredible that it convinced me that this was the place to practice. And that's how it initially evolved. I was here for about 6 or 7 years and then I saw that I was immensely busy because this was in the forerunner of the Marquette General Hospital single hospital system. At the time that I came you are probably aware that they had both St. Mary's and, they didn't call it Marquette General, it was St. Luke's hospital. I worked at both places. While we have emergency room physicians today, I think there are about 6, I worked as the only emergency room doctor in the first years of [with] Dr. Bennett. He and I shared experiences there in the E.R. If we were on call we took care of all of the E.R. patients, whether it was St. Mary's or St. Luke's, so it was really an extraordinarily busy practice. With it you picked up a certain degree of family medicine [patients] because people sort of identify you and they say, "Oh, this new doctor he's pretty good. I think we'll see him as our private doctor". So part of the practice was built up in this fashion. Again, that was satisfying because I enjoyed seeing people. This was more or less how it evolved. Dr. Mudge (Thomas J. Mudge, MD, general surgery) was the only other general surgeon and he worked in Ishpeming primarily. He hardly ever came over to Marquette General [Hospital] so it was just Dr. Bennett and myself who took care of most of the surgery here.

RMM: Now you said you had alternating weekends that you were on call?

EL: Every other weekend, every other night, we were on call. So you could only count on a night's sleep on alternate nights. It was pretty exhausting and I couldn't see where the other surgeon (Dr. Leo Lindquist) said he wasn't busy because it was just…I think it was probably a matter of personality. The other surgeon, the one who had left was, well, he was a little diseffective with the practice and his wife was unhappy. Part of the key of staying in Marquette as a professional is that the wife has to be happy and content with the community. My wife was just delighted, she liked the church and she got involved with the auxiliary at the hospital and of course [we had] the children to raise. We had four young children so she was busy. We were able to enjoy the geography quite a bit because we did take vacations. We did just what other people did. We bought little camps and used these as escapes to recharge the batteries so to speak.

RMM: Could you give your wife's name?

EL: Constance, and four children of course. The other thing that we did - I'm not sure you're aware of this - we did have the Cliffs Dow Royal Oak charcoal industry here which was on the lake shore (in north Marquette between Presque Isle Ave. and Lakeshore Boulevard, between Wright and Hawley streets). Dr. Bennett was the industrial physician for them and I was tied in with that too. So we took care of the industrial medicine here, so to speak, because that was quite the only industry in Marquette. I'm not speaking of the iron ore, that was entirely different because that's Ishpeming/Negaunee but we took care of these charcoal people. That had its plusses and minuses. It didn't appeal to me too much because they would appear in the office for their physical exams or their knees (knee problems) and they'd be black. They'd track it in on the rug and charcoal would be at the entry and all the way through. It would be all over the walls and by the time you'd finish the day your hands would be black. It was a unique experience but Dr. Bennett loved those charcoal workers. Eventually it got to be a chore because both of us where very busy with the general surgery.

RMM: Now this was just for general checkups and what not?

EL: Well, it was for their illnesses as well because we were their industrial physicians. If one of them happened to get a burn from preparing the charcoal, chemical injury, and whatnot, we had to take care of them but that represented a very small fraction of the business. Most of them did have their own family doctors.

RMM: You weren't getting all of the workers then.

EL: Oh no, there were about 300, I think, workers and we were just responsible for doing the health physicals when they went to work for employment and we took care of anything related to industrial trauma, if you will, or injury, a mishap of one thing or another. That lasted for several years but of course the charcoal plants dissolved. The big problem was [that] the transportation cost for the charcoal being delivered out of Marquette to other points was almost prohibitive. It went out by train. It didn't go out by ships as the iron ore does here, so they failed. That phase of our medical practice really went out of the way. My observation in Marquette was that we did have a fairly good specialty base. We had orthopedic surgeons. (I'm thinking of the surgical end). I don't know who would cover the medical end, although we did have Dr. English, Dr. Wright [and] a few other internists who had their board certification. Dr. Kronschnabel (ENT, otorhinolaryngology) and we did have a urologist. His name was Dr. Hettel. He didn't stay here too long. We had several radiologists. Dr. Bolitho (T. Boyd Bolitho, MD) was one and I think there where others who were not credentialed but he was credentialed. [The area had] a lot of family practitioners. And these were men who had embarked on medicine in the 40's and 50's and had pretty much controlled the medical environment here in Marquette until the specialists

began to come in. Although, interestingly enough, even though Dr. Bennett and I were doing the general surgery a lot of these family doctors (general practioners) were doing general surgeries as well. As things went on they were doing less and less and we were doing more and more.

RMM: Now they were doing it because there was no one else?

EL: There was no one else. Well, the way medicine evolved in 30's and 40's is pretty much a family doctor type thing. You went to your doctor and that doctor was expected to deliver your children, to do simple operations and to carry on your health care. Also they did emergency room work as well. I was more or less in the, you might say, transition between that group and the advent of the specialty group. That would be these people I mentioned, the orthopedic people, the urologist, and so forth. There was a little bit of [a] clash that occurred when I arrived here. Dr. Bennett, he told me that this was a problem but it wasn't one that really affected our practice and there weren't really any axes to grind, so to speak. [We] were accepted. This is with the two hospitals, that's the St. Luke's and the St. Mary's Hospitals.

RMM: Is there any way to compare and contrast the two hospitals while you were working there? I'm asking this more for insight about the hospitals and sort of other interviews I've covered.

EL: I don't know what the others have told you. The profile of the two hospitals was similar. Most of the physicians practiced at the two hospitals although some, by their own choosing, just picked one or the other to do their principle care but both of them offered all services. They offered medicine, surgery, obstetrics, child care, this type of thing, although the principal child care was done here (St. Luke's). You probably know Dr. Matthews (Norman Matthews, MD, pediatrician). He was in charge of the Childrens Clinic, the states children's clinic, and most of the children's illness that occurred here locally he oversaw. Illnesses that occurred here locally he oversaw through this Crippled Childrens Clinic. They called it Crippled Children's only because there were a lot of polio disadvantaged kids that he saw and then Dr. Elzinga (Eugene Elzinga, MD, orthopedic surgeon) operated on many of them. The other pediatrician was Cooperstock (Moses Cooperstock, MD) and [I] may be bogging you down with names here but you probably should know these. Cooperstock was a very loved physician and one of the ones who had first identified the problem with robin egg babies. It turned out that many of them had a condition call pyloric stenosis that's a little tumor at the end of the stomach. It 's from an overgrowth of muscle and it required emergency surgery and he was the one that first recognized the condition and Dr. Bennett was the one that operated on them and then showed me how to do it and then I took it up as well. That was a little first time thing that I thought you should know. One thing that I observed though is that Marquette was beginning to evolve in the 60's to meet more and more sophisticated needs; I'm speaking to surgical needs. I recognized that for example a field that wasn't even addressed was vascular surgery. You know what was operating

on. Vascular surgery is a surgery of the blood vessels and it deals with a variety of conditions and was becoming very dominant on the national scene in terms of an ongoing education. Most surgeons, and myself included, would go to national meetings and would hear more and more about certain types of surgery that was evolving and was being performed in cities and also in communities the size of Marquette. The other thing I saw that was needed up here was thoracic surgery and that was a field that demanded attention because there is a fair incidence of cancer with the iron miners. It's not as dominant as with coal miners with which silicosis is a problem. I may be using too much technical [terminology] but there is a fair incidence of cancer of the lung and a lot of these people were coming through clinics and we'd have to refer them elsewhere for their diagnosis and treatment options. I thought, "Gee, this isn't too good. I think we should address this". I pointed that out to Dr. Bennett and he said, "Well, I'm not going to do it. If you're interested in doing this you could pursue it". Well, let's just say that in the back of my mind I'd consider it but in the meantime the practice was going on pretty well, quite busy. The two hospitals were doing their thing on a parallel basis; I'd say fairly evenly weighted although it was pretty obvious that Marquette General (St. Luke's, at this time, before the merger) was being a little bit more creative and a little bit more generous with physicians in terms of buying equipment and encouraging them to develop talents that they had and that the hospital could use. This is the time that the merger of the two hospitals was being discussed in the mid 60's. Eventually, as others have probably brought out, it was pretty obvious that just one hospital would be the best. One that St. Mary's.....

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RMM: Okay

EL: Decided that they would pull out and it was done in an amicable way. They saw the future and it (St. Mary's Hospital) was becoming less and less used as St. Luke's hospital began to develop its interests in cultivating physician's talents and being able to offer more services. That's ultimately how St. Mary's left the area. I presume Dr. English probably filled you in, Dr. Risner there. In terms of my own interests, I decided in the late 60's, early 70's, that vascular surgery and chest surgery were just not being addressed properly up here. Furthermore I had a very strong interest in both fields. The opportunity came up to take a fellowship with Dr. Michael DeBakey. I don't know if that name strikes anything. He was the world's most famous vascular surgeon. He was the world's most famous vascular surgeon and his clinic at Baylor (Baylor University) in Houston, Texas, was considered to be the center for treatment of these conditions and he was most innovative and he had fellowships for surgeons. We decided, with Dr. Bennett's approval, because he said, "You do this, you come back". I said "Yep, I'll come back because I like it up here". We were well settled. After all, we were here almost a decade but I just craved getting a "sabbatical fellowship". It was for six months so we went down there to Baylor. The experience was just overwhelming. He did an enormous amount of surgery, Dr.

DeBakey and his colleges, and it was an experience for us because my wife went down with all of the kids and they went into schools there and they mixed with Mexican children, so it was a new culture for us, a big city. We thought, "Gosh, Houston isn't too bad. We have to look this over a little more carefully." The only problem was it was too hot and it was really [in the] deep south and we weren't too certain that that was it. After 6 months my wife and I sat down. I told her, "We are going have to do more of this in order to get our certification to be able to come back to Marquette. If that's what we're going to do, we're going to have to take another year and a half of thoracic [surgical training fellowship]". (That would be open heart surgery and lung surgery and surgery of the blood vessels). I told this to Dr. Bennett and he said, "Well, you can consider that but I'm not sure what's going to happen up here". At that time, because it was so busy, Dr. Keplinger (James Keplinger, MD, general surgery) had arrived. Again, you should probably interview him. He and Dr. Mudge decided to joint Dr. Bennett and form a surgical group. This was in the cards anyway when I left [for Houston]. They joined and it was, again, a reasonable thing to do because the evolution of medicine up here was to form groups so that you didn't have to consider yourself on call every other night. So this situation of cooperation between Dr. Mudge and this new man, Dr. Keplinger, it worked out very well. And it was [at] this time that I decided that if I leave Dr. Bennett he has these other two people to help him anyway. So that's in the background just before going for the fellowship. So the fellowship was complete there and we decided that we'd go to look over other places. We looked at Ochsner Clinic in New Orleans. We looked at Cleveland Clinic in Ohio. I only wanted to see the best ones and we looked over Wake Forest [University Medical Center] in Winston-Salem, [North Carolina] and they saw that I was a mature surgeon and not just a young man barking on his residency although this was really residency that I was going into. They all offered me a position and we decided that we liked the North Carolina one the best. We liked the geography and then I kind of tuned in on them when I had my interviews. So then we proceeded to settle and that was in [Winston]-Salem. We stayed there for a year and a half and completed [the] thoracic surgery and open heart surgery program there. It was at this time in 1973 that I completed all of this stuff and the opportunity to come back here and start a program in open heart surgery was pretty attractive. And furthermore, Dr. Hunter (Allan F. Hunter, MD) from the University of Michigan was interested in coming up here. Have you interviewed him?

RMM: Yep.

EL: He wanted to start an open heart program so we wanted to collaborate. There's only one thing; I wasn't as interested in the open heart as I was in vascular and chest [surgery] but I agreed to help him start the program up here because he needed help.

RMM: So then you were sort of influential then in getting Hunter to come up?

EL: I was influential when he knew that [there was] another thoracic surgeon, particularly a guy that had been here for a while. I guess we actually met at the time I returned but the thing that veered my interest to just doing the pure chest surgery was an experience in North Carolina. We were assigned 3 months working in a TB (tuberculosis) hospital. That's the most complicated type of chest surgery there is. It was a wonderful experience. It was in Black Mountain, North Carolina, which is on the opposite end of the state; it's in the western part of the state. That's where they assigned the residents and it turned out to just be an experience. I said, "This I like doing. I just want to do chest surgery". The open heart, well it's alright. I was doing that but it didn't interest me as much. I was offered a job there, in Nashville, as a matter of fact, in a nearby community to join a group, to do open heart surgery and thoracic [surgery] but we decided that we wanted to get back to Marquette. We liked it. We had a home up here anyways. So we came back and Dr. Hunter came into practice and the first thing we did was we started a dog lab over here at the old St. Mary's. We had space there and the hospital wasn't being used and the first thing we did just to get our talents going was to operate on dogs. He probably mentioned that to you. So he did that for about six months and then he started to do the open heart surgery here and I told him I'd like to do just the chest and the vascular but I would help him if he needed it. From there Dr. Hunter probably filled you in about his people that he got here, so I don't have to do that. I stuck pretty much purely to thoracic and did all of that program aggressively here and the vascular [surgery]. I also rejoined the general surgeons (Surgical Associates of Marquette) and continued to do general surgery as well and this is pretty much what transpired over the next 20 years or so, my practice. That carries me through to about 1992 and that's when I decided to retire, in my early 60's. I was in practice 30 years.

RMM: Where did you have your office, your private office and so on?

EL: Okay. When we first came into practice we used this building directly adjacent to the old St. Luke's. It's a school administration building. (The Frazier building, currently home of the U.P. Blood Bank, on Hebard Court and College Ave., Southeast corner).

RMM: Right across the street?

EL: Just across the street from here, not from Peter White but directly across from Marquette General. It's now used as I think as a school or administrative building. We had our office practice there and then what we did was to join the medical group which had formed. Dr. Wright was pretty much the spearhead of that (to develop a medical building corporation) and we did, and we built that (The Marquette Medical-Dental Center, later the Upper Peninsula Medical Center or Peninsula Medical, 1414 West Fair Avenue in Marquette). I was one of the original members over there with Dr. Bennett so we practiced outpatient care between those two locations. This one (On Hebard Ct. and College Ave.) I think we were in only about 4 or 5 years

and then we developed this marvelous medical building which has gone through three expansions. What it is today; it's a magnificent affair.

RMM: So you were the, today they have the vascular surgery under the?

EL: Okay, vascular surgery today is pretty much done by the thoracic surgeons.

RMM: (Inaudible phrase - likely a reference to the cardiology group started by Dr. George Patrick and Dr. Thomas LeGalley).

EL: no, those were cardiologists. This (cardiothoracic and vascular surgeons) would be Dr. Baldwin, he's the open heart surgeon and Dr. Johnson (Joel Johnson, MD). Joel Johnson does only vascular [surgery] and he does it at Bell hospital (Francis A. Bell Memorial Hospital in Ishpeming, MI, - later UPHS Bell). I'd say he probably does the bulk of the vascular surgery now in the county and the Upper Peninsula. He's a very skilled surgeon. He was a thoracic surgeon and decided that's what he wanted to do (vascular surgery). They (Bell Hospital) gave him everything he needed, a laboratory there and a nice environment to work in.

RMM: So he was originally in Marquette and then went up there?

EL: That's right. He came in as an independent thoracic surgeon here and he didn't work with Dr. Hunter. He developed his own practice pretty much. Dr. Hunter had, I think, at least two thoracic surgeons who worked with him. He might have mentioned the name Militano (Thomas Militano (cardiothoracic and vascular surgeon) to you. He had one other man earlier than that; I can't recall his name. So it was Dr. Hunter and one other that did the open heart surgery up here.

RMM: Now when there is only one physician to do a type of surgery then he doesn't get every other night at all? He's on call…

EL: Pretty much. It has to be a labor of love but fortunately in vascular surgery, except for a few conditions, there are very few emergencies. There are a few, like ruptured aneurisms and a stroke, [in] which you have to clean out an artery, but you're pretty much able to be an 8-5 individual, and weekends, as long as you leave your telephone number. It's livable. You can do that.

RMM: Now just to get your reaction to it, one of the stories that Dr. Wojcik (John Wojcik, MD, gastroenterologist), John Wojcik, told me - that he had a place on Lakewood Lane because at the time in the 70's he didn't have a cell phone. He had to have a direct open area between the hospital and his telephone so he couldn't have a camp inland someplace on some lake but it had to be on Lake Superior. I was just wondering if that was ever a problem?

EL: Yes it was. I'll have to give you an anecdote. That's one that I omitted. We had a camp in Gwinn, on Pike Lake or Shag lake, 30 miles from here. And since I was doing the vascular and the chest [surgery] [and] I was the only one doing it initially there (at Marquette General Hospital) [as well as] general surgery, (this was when Matt Bennett and I were alternating our calls), I was needed. It was sort of interesting how they had to get a hold of me even though he was on call. He wouldn't do any of this work (vascular and chest surgeries). Jack's Bar, are you familiar with where that is? It's just outside of Gwinn.

RMM: yeah.

EL: The hospital would telephone them because I didn't have a telephone (at our camp) at the time. I don't know quite why. I think I had some problems with the telephone company coming into the cottage at the lake and they gave me all kinds of trouble because they didn't have lines out there. And, of course, there are no cell phones, so what had to happen was they'd call Jack's Bar and Jack's Bar would call the Gwinn police and the police would come out to my camp and often times they'd appear at 2 am and say, "Listen doc, you're needed. You better go in and take a phone [call]. I would take a phone [call] at Jack's Bar.

RMM: Oh so you'd go to Jack's Bar?

EL: I'd go to Jack's Bar, take the phone, find out what they needed. If it's something I could handle on the phone - it might have been a patient that I had in the hospital - I'd take care of it. Otherwise, I'd have to go in. But that's how communication was. If you were going to have a camp and were going to have a practice, you'd do that.

RMM: So this was about what year?

EL: These years were when I was with Dr. Bennett, the early years. I'd say they were in pretty much the late 60's. He and I were together and I think this was even before Dr. Mudge and Dr. Keplinger merged with us. I'd never do it, for example, when I was on call. That would be prohibitive. It was all at night so that you'd have to respond to an emergency of some type. This was strictly when he was here. He would call me to come in to take care of something he didn't want to take care of that was pretty much it. As things went on Dr. Bennett stayed pretty much in

his own little confined comfort zone and I was doing more things that were innovative in the community. I was one of the first ones who was doing hand surgery for example. Preparing tendon injuries to the hand. We had two orthopedic surgeons: Dr. Elzinga wasn't doing it (hand surgery) at all; Dr. Lyons (James W. Lyons, MD, orthopedic surgeon), he tended to avoid that and we didn't have a plastic surgeon. This was before the advent of ……Ann Arnold (Constance Arnold, MD) the first plastic surgeon here. So I was doing hand surgery and often times I would come in and take care of that. The reason I got interested in that is because I attended a number of seminars in Chicago and I got to know the hand trauma surgeons and I went and attended a number of lectures and also some clinics and picked up how to do it. That's how surgeons learn. They keep their skills up. There are short periods of training, or in the case of thoracic [surgery] I wound up with two years [of training] but with hand surgery I was able to just go down on weekends and learn some of the tricks.

RMM: Now this in terms of doing some of this stuff and learning and so on, this was, you could have just sat here and continued with what you were doing when you first arrived and not added anything. It would have been considered successful?

EL: Oh very much so.

RMM: You had this interest to expand your knowledge?

EL: Yeah, I needed the sabbatical. After let's just say, after 10 years of the rat race here I said this, "I've got to confine my interests a little bit". I enjoyed the family practice contact but that was beginning to become less dominant in the practice because I was too busy with the surgery. I really wanted to do more and it turned out that the thoracic [surgery] was the thing in [along with] vascular [surgical] fields that I enjoyed the most. We started the first diagnostic clinic here for bronchoscopies. No one was doing these. Dr. Hammerstrom (Carl F. Hammerstrom, MD) had arrived but as a pulmonary man he hadn't initially trained in bronchoscopes so I was doing those. First of all we were doing what are called rigid bronchoscopies. It's [done using] a long rigid scope and then we were using a flexible instrument (flexible fiberoptic bronchoscope) much as they use flexible instruments in doing colon work (colonoscopies) for example. I'm just giving you things as they occur to me here. So, that's how it evolved and then, from there, doing the diagnostic work, you pick up the problems and that's how I got to surgery.

RMM: Well you were on the point of change in terms of becoming more specialized?

EL: More specialized

RMM: And I mean medicine in general was becoming more specialized and you where involved in it.

EL: Yeah, as a matter of fact, general surgery, in the years that I went [was trained], was such that the general surgeon in the 50's, in the years I was trained, was really able to do a great deal in the other [surgical] fields. A general surgeon, for example, could do orthopedics, he could easily set bones and nail bones and put in pins and braces and things of that order. We were able to do urology, a limited amount. We were able to do, and I did that here, we were able to do neurosurgery. Maybe Dr. Brish (Adam Brish, MD, neurosurgeon) didn't mention this to you but Dr. Bennett and I did the first burr holes for head injuries. We would drill skulls and drain blood clots in people who came up because that's a necessary thing. So we did that and we also did gynecology, female surgery. I [initially] felt comfortable doing all of these fields but as time went on it was very obvious to me in the 60's, late 60's and 70's, that you really needed to, in order to keep abreast and to treat the public [patients] properly, address yourself to a more specific specialty. We were all going in that direction and as a result people like Dr. Bennett, Dr. Mudge, Dr. Keplinger, they were being closed in more and more as more specialties were arising and more people were coming to the area here and I wanted to be part of that. Therefore, that's what I did myself, and I found it very satisfying because I was able to it and still supported my partners. And I'd still do general surgery and since I was part of the group I did my share even when I had finished that training program.

RMM: Now were you kept busy in your new specialty?

EL: Quite busy, yeah. I was quite satisfied doing vascular [procedures] in the chest and thoracic [surgery]. Initially [I was] helping Dr. Hunter but I backed off of that. He got his own helpers there with time and he's the one really responsible for developing the open heart surgery program here.

RMM: I have a few spelling questions here. ENT?

EL: Ear, Nose, and Throat.

RMM: Okay and how do you spell pyloric?

EL: Pyloric stenosis

RMM: Okay, and Debakey.

EL: DeBakey, it was Lebanese.

RMM: You talk about the Ochsner Clinic

EL: Ochsner. It's a very famous clinic.

RMM: I was familiar with the name, you know, New Orleans, just so we get that. Then you had a bron…

EL: Bronchoscopy, sorry about the medical terms.

RMM: Something about a burr.

EL: That's burr holes. It's just, Dr. Brish may have mentioned it to you, in order to see a person with head injury, at the time, you had to operate on them in a hurry, otherwise they die. There wouldn't be any time to send them elsewhere. So the treatment there, after you recognize the condition, and there were certain diagnostic features of it, you just use a drill, an ordinary drill, and drill through the skull. And once you get to the layer overlying the brain you just make a little cut in the layer; it's kind of an envelope around the brain. These clots [of blood] would be bulging out and it would release that blood clot and the patient would get better.

RMM: So that was it?

EL: That's all there was to it. So we were doing that type of neurosurgery. Dr. Bennett was actually doing it before I was.

RMM: But if you didn't do it the person would…

EL: Oh they would die. You'd have to do that. That's the other reason that I was very interested in vascular [surgery] because there were certain conditions that presented themselves where, again, you had to act on the spot or the person would die. For example, a ruptured blood vessel (an aneurysm) in the body. We had had several of them and you just felt kind of helpless because there was no one around doing this. So, I just felt we just had to develop this facility (capability) and a few of these procedures I was the first one to do [in Marquette] (the aneurysm work). And [I was] also the first one to do another procedure called carotid endarterectomy (CEA). There are two major vessels (arteries) in the neck, the carotid arteries, one on each side. And people

would present with, “Oh, I can’t see out of this eye. Suddenly a shade came over the eye and I felt numb one side of my body”. You’d recognize this as an imminent stroke and we did the angiography (arteriography). That’s where you poke a needle into the lower part of the vessel and profile it (using injected radiologic contrast) and show that that’s what their problem was and you could do this procedure under local anesthesia. Just open up (make a surgical incision) next to the artery under local anesthesia, while they were awake, and clean this artery out. Usually a lot of arterial sclerosis, fat debris and so forth but the real emergency procedure was the abdominal aneurysm. These people would come in in shock; complain of severe abdominal pain. You do an x-ray and you can identify it (the leaking aneurysm) and if you didn’t operate on it they’d die. They had to be operated on. Aneurysmectomy. These are the things that triggered my interst in doing emergency - well, to train in vascular surgery. That is the reason I went down to [train with] DeBakey to learn these [procedures]. I wasn’t interested in the open heart [surgery] one bit. I really wanted to get more training in doing these (vascular surgery procedures) as well as thoracic surgery. There are not too many emergencies in thoracic surgery except for injuries. You probably remember when Ron Reagan (40th U.S. President Ronald Reagan) was shot in the chest with a small weapon that did him in and he went to Georgetown [University Hospital] and they operate on him in emergency fashion. A thoracic surgeon had to take out that part of the lung that was injured and saved his life.

RMM: So these where all sorts of very necessary emergency procedures to save lives?

EL: That’s correct.

RMM: But if you didn’t operate on them they would have died?

EL: I’ll indicate that. Thoracic surgery would be, well like gunshot……

End Tape 1 side B

MAGNAGI, M. RUSSEL (RMM): Okay so all of these procedures that you’ve written down were emergencies which would have resulted in death.

LINCKE, ERIC (EL): Yeah, when you’re up in an area like this you’re really isolated medically speaking. Think about it. The nearest large clinics that could address some of these needs would be the twin cities going in that direction, maybe Duluth. Even Duluth was going through, although a larger city than Marquette, it was going through the growth and development of some

of these procedures that were evolving,. I'd say, in this transition period and of course Ann Arbor. We didn't have helicopters, no planes.

RMM: Then Green Bay was in the same category as Duluth?

EL: Green Bay I'd say was a little further ahead than Duluth. They might have been able to address some of these things.

RMM: So the next stop then would have been Milwaukee.

EL: That's right, and Chicago, just too far away for people who had these conditions. Either you address them on the spot or they (the patients) are gone. I couldn't see it myself, having seen a few crises occur [in] our accident room here, motorcycle accidents, car accidents and so forth. Some of these issues of vascular and major chest injuries, even cardiac injuries, heart injuries, we couldn't handle them [in Marquette].

RMM: But you knew that with training you could do?

EL: Yeah, as a general surgeon, I really didn't have the background to do anything as complex as some of these things so I felt that going away would be important so that's when the sabbatical came up and I wanted to pursue these in particular. The open heart [surgical training] was part of the package and that too was evolving quite rapidly. As Dr. Hunter probably mentioned to you, the big thing with the open heart surgery was the bypass concept. That was undergoing very dramatic changes, particularly in the early 70's, late 60's, as they began to find out that you could actually improve the lives of people that had blocked arteries of the heart by doing bypasses to them. And, quite frankly, that particular surgery represented 80% or 90 % of what open heart surgeons where doing, the bypass. It was a real bonanza and they were doing this down in Houston as well. They also doing cardiac transplants. That era came about pretty much in the late 60's. You may remember Christian Barnard (Dr. Christian Barnard of Cape Town, South Africa). Historically speaking, he's the first surgeon to transplant a chimpanzee heart into a man and it worked and it went from there.

RMM: So that was kind of an era of tremendous transition that was going on in terms of the medical, so you kind of right in the middle of it. Today it's kind of in place?

EL: Today it's in place and a young surgeon or a young medically trained person from his medical school can pretty much select, oh…you could be a trauma surgeon, just do nothing but

act on trauma. He can be just a hand surgeon. There are those surgeons that only do hand surgeries for example. There is the pure thoracic surgeon, which I wanted to be (you just operate on everything within the chest cavity except the heart, unless, there's certain things about the heart you can do). And the vascular, you could be a vascular surgeon, a pure vascular surgeon as Dr. Johnson is doing now in Ishpeming. It's become so circumscribed that each of the various fields of surgery are so well defined now that you just don't go outside them anymore. [In] The era that Dr. Bennett and I practiced you were a much broader trained individual and you did more overlap into these other fields and it was appropriate because these other fields were not that [well] defined. So, you hit the nail on the head. It was entirely a transition period and this is what made it well, I found it fun. It was an ordeal to a certain extent because you had to… Imagine yourself as a, well, a professor here at Northern, and you just tell your collegues, "Well, listen, I want to go away so I can learn a little bit more about this facet of European history that no one seems to address in the department". They'd say, "Well, I suppose you can do that but who's going to take care of your classes?" It's the same thing with a surgeon. He's got a responsible practice. His patients expect him to be there so others have to pick it up (provide coverage for his patients). So that's the big key.

RMM: Then, the other part of that is that people attach themselves to their physician and once you're gone that relationship is then broken.

EL: Very much so, yeah. Particularly if you're doing an element of family practice and inspite of all the years that I was in practice, over 30-35 years, I was still seeing people that wanted to have their physical exams done by me. I would tell them that we had plenty of internists. I gently nudged them but there were some that stuck [with me in my practice]. It's just something that you have to accept. I like people and ….

RMM: I just got this sense that this was, he was doing it as a favor to the community but his focus was on….

EL: I think that's pretty much where I stood in my own particular practice. Medicine, as it has evolved in last 30-40 years, has become so complex that there is no physician that, certainly in the surgical fields, that can say, "I'm going to plan and do this and this and all of this". But in the year I was in training, even in Rochester, New York, which was a community of over 500,000, there where surgeons that where just doing everything. We had one of the general surgeons who kind of opened my eyes up to thoracic [surgery]. He would take me over to the sanitarium. We had a TB (tuberculosis) sanitarium at the time and he would operate there two or three times a month and he would take me over there to assist him. I thought it was pretty neat them. This kind of reawakened my interest later as I came up here. I really liked doing that kind of work. These surgeons where doing everything. They were doing vascular and they were doing gynecology and they were doing abdominal surgery and a limited amount of chest because

there was no one around that was identified as a "thoracic surgeon". But, nowadays you just go right down and straight focus. That's pretty much the way it is.

RMM: Now at the end of your medical, how did you get into clock and all that?

EL: You're worried about (inaudible) [probably referred to repairing clocks]. I got interested in that as a hobby before I retired. I took a correspondence course. I thought "I've got to do something other than read medical journals and operate". I was getting close to 60 and I thought, as I saw life ahead, I thought, "This is pretty neat, learning how to fix a clock, because it's such a complicated mechanism, as is a watch." We visited our daughter in the twin cities and they did have a watch [and] clocks. While we were over there [we] just visited and had a delightful interview by the watch instructor who was handicapped. He was wheelchaired for polio. A brilliant person, highly regarded, and he talked us into spending a 9 month period with him. I had to negotiate that with the other surgeons and they kind of look (inaudible) mad. This was in '92. I said, "Listen, I want to go away for 9 months and learn this". And they said, "Well, I don't know. You've got your practice, that's the usual thing, and we doubt very much that we'll be able to keep your place open". And I said, "That's okay". I pretty much at the time became quite interested in it and fortunately my wife liked it too for some strange reason and we went there and we spent our 9 months. By this time they had hired other surgeons here (in Marquette) and I thought, "Well, I can still come back". It was sort of a letdown period with them but we went from there to…instead of just 9 months we went several more months to an apprenticeship with a man down in Kendallville, Indiana, who was head of the watchmakers association nationally, a very well known man. And he taught me all of the tricks of the trade, doing watches and clocks, and [I] came back here and I saw that this [was an] opportunity to really open up a good little business and a hobby and I said, "That's enough medicine".

RMM: So kind of because of the watch training you would then…your position had been kind of put on the shelf?

EL: It was on the shelf and they had to fill it and I told them so be it. I'd been in practice from '57 to '92 and I thought that's enough years in medicine. I was in my early 60's, younger that you, but this absorbed us and we cultivated the watch and clock practice and made house calls and we still do it. It's something you control. We don't advertise, it's entirely word of mouth.

RMM: And you still get a lot of business?

EL: Oh an enormous amount of business. There's no lacking in business.

RMM: Is there any competition in Marquette?

EL: No there is no competition. The only competition that didn't turn out to be competition was Jandron (Jandrons Fine Jewelry in Marquette) who has a watchmaker there. Keskimaki (Keskimaki Watch Repair) retired; he was out. So there was no one doing any watch work and then suddenly the watchmaker at Jandrons said, "I'm not going to [do] mechanical watch repair anymore; I don't have the time for it". So, that opened the flood up and [I] began to do watches for jewelers throughout the UP. I did them for people in Houghton-Hancock and L'anse and Ishpeming, Negaunee. That's died out somewhat because mechanical watches are not as popular. Is yours a mechanical watch by the way? Probably a quartz watch, battery?

RMM: Oh yeah battery.

EL: Well that's pretty much supplanted mechanical watches but people…

RMM: These have to be repaired or?

EL: They can be repaired.

RMM: They can be.

EL: Oh, yeah, [I have] repaired quite a few of those. There are some wonderful watches out there that.... it's just like surgery. It's a wonderful field to be in. It too has evolved. There have been transitions from these old mechanical watches that your father and your grandfather had, pocket watches, Elgins, _____ and Hamilton's to early electronic movements that are more complicated than the quartz ones. Don't get me into that or I'll be here an hour telling you about this.

RMM: As a matter of fact I have two. One is my moms, I think, watch when she graduated from high school or something in 1920 something and then, my dads, my granddads pocket watch which is just a….

EL: Probably an old Elgin.

RMM: Inexpensive, yeah. I think that my dad also had a Hamilton.

EL: Remember, all of these are companies that have since ceased operation because the Swiss manufacturers have pretty much taken over it. I got very interested in the science of horology, and again, Marquette's been ideal for that because there's only one watch maker and there's a guy in Gwinn that does clocks and there's just plenty of business. My wife does all of the Grandfather clocks. She runs around all of these houses. She sees at least two a week. She does house calls. If they're too complicated she has me come along and I help her take the clocks out and then we take them home and we repair them and then we take them back. It's been a very, very absorbing period of time.

RMM: It sounds like a whole new full time career.

EL: It is a full time career but I wanted to do this. The medicine, I loved the medicine. I like the fields I was in but the time came that I really got more interested in pursuing this. You should know this: in '94 about, after we finished clock school and we were doing this work, we both decided to go back to Northern. You knew that. See, my wife took your course. She said, "Be sure you tell him this". She took your course in Mexican history and she said, "That was it, I've got to do more". So she went ahead and finished her degree '94-'98. Both of us went for four years to Northern and we took the courses for credit. She took history courses and all the other necessary prerequisites. I decided, "Well, German and math are sort of interesting" so I became a math major and finished the major in math.

RMM: Oh, so you got a degree then or you just did the major?

EL: No, I got a degree, a Bachelor's in Math. They gave us some credit for what we had done with premed, not much. I was surprised how little credit they gave for that. The only thing we could [get credit for] was some of the very elementary things that freshman take. Mainly freshman composition, the writing and I think, oh, maybe two or three other courses.

RMM: Probably some of the math requirements.

EL: Yeah, but I started right in with calculus because I had math in college. My wife was able to bypass the math, she wasn't interested in math. I was the last German major there. They didn't have a German major. They dropped it to a minor, it still is a minor.

RMM: They've been talking about upgrading it back to a major.

EL: I would think so. I still take course's there. I'm taking, right now I'm taking, their advanced German culture course which is conducted in German with Dr. Sherman over there. A nice young man whom I think they brought on the last two or three years. This is the only one that is conducted in German. You walk into the class and there isn't a word of English. I like that because I never had that during the years I was at Northern, so that's been quite nice. So we did that and we did the watch and clock work and then subsequently we both go back and take a course here and there. Now it's at the audit level. I don't take any more credit. It's just too much work. I had to get that in.

RMM: Towards the end here, is there anything that I didn't ask you?

EL: I think we covered it pretty much. I think I've given you the evolution of the time process. I'm just thinking of the two hospitals here. I think, unless the other men have filled you in on that, it was a peaceful transition of medicine, the phasing out of St. Mary's. It just was not necessary for a community of this size to have two hospitals, two separate buildings, pieces of real estate, physicians running back and forth, some degree of competition. So that was important and the minute that occurred, the time that that occurred, Marquette General just took off. It became Marquette General and we had a very effective administrator, Neldberg. They probably have mentioned him to you, or you remember him, Bob Neldberg. It [He] was in the spirit of supporting the physicians as was the Marquette [General] Hospital Board. Hmm….got another block here, a senior block....Elwood Mattson. He and the others had the foresight of seeing that if they provided the tools, speaking of the surgery department, they provided the tools then that particular branch would flourish and that's pretty much what the story has been when Al Hunter and I got here. It was a big commitment for the hospital to start open heart surgery because we had to buy the machines and we had to buy, you have to have, the talent and the people to work with. It was quite a large project for them to embark on this and it was uncertain whether it was going to be successful but it turned out to be very successful as did the thoracic and vascular [surgery programs]. These other fields that are involved here, like Joel Johnson's work at Ishpeming, it keeps good people here and fortunately there is enough draw for these [services] from the whole UP that the hospital, I think, is pretty successful.

If you are aware of this, there is more cooperation between the Marquette General [Hospital] and the [Francis A. Bell Memorial] Hospital of Ishpeming. Marquette General has also developed clinics throughout the UP (in Iron Mountain, Escanaba, Manistique), I believe, so that this feeds into Marquette General. I'd say it's kind of a synergistic [relationship].

RMM: Just kind of adding to that, a few weeks ago the former President Bill Vandament was up here and had a urinary problem and then he had some sort of a heart thing and they decided to go back to Long Beach. Everybody here kind of said, "Geese, it's too bad they didn't stay because

just knowing some of the people and so and so on and they still haven't operated on him for his bladder".

EL: Prostate problems.

RMM: A blockage, so and so on, and then the doctors here sent him a CD explaining the whole thing. The doctor didn't even look at them (the CD from Marquette). I guess he thought, "A bunch of hicks up in Marquette, Michigan. I might not even bother". Then the anesthesiologist said, "Wait a minute before I start loading this guy up with all of these chemicals. I don't want him having a heart attack". So they had to stop the surgery. Bill was on the table. So you start hearing stories like that. Here you are in the Los Angeles basin, this is where you'd think things are at, and it would have been wiser to have the operation taken care of here. Inconvenient but…

EL: Well, had he had the time and the inclination to stay here? I don't know the arrangements he had. I knew Bill Vandament well because he was [a] Kiwanian and I got to know him through Kiwanis quite well, a highly regarded man, wonderful for the university. I think he was, personally, I think he was one of the best.

RMM: We were and we still are good friends. Alright I see there is a time at the door. Okay, well, thank you very much.

EL: I think we covered it, most things. I won't take four hours with you. Dr. English, I'm sure, did fill you in and I'm sure there is a lot of overlap that I've said.

RMM: No, but the thing is that each of the stories are very important. There is some overlap but then there is heart of your story there. That's what's important.

EL: When you digest these various stories, you might be confused by one or the other of us. Don't hesitate to call.

RMM: Well what I'm going to do is we'll have this transcribed and we'll send you a rough copy with spacing. We'll like double space the whole thing. You can add once you see it in writing. You might decide to add something to it and make corrections.

EL: I organized this pretty much in my own mind how I wanted to do it. I might have gone through it a little fast with you but there's a lot of personal anecdotes. There still can be many, many more.

RMM: But when it gets done you might want to add something you know.

EL: I think what you're doing is a wonderful thing because I don't believe there's anyone that's embarked on the history of medicine here in the UP.

RMM: That's correct, yeah. So we keep doing these interviews and we're saving the memories and we are saving the history from the past.

EL: Did Dr. Mudge help you a fair amount?

RMM: Oh yeah, no all of them have been... well, we had one from a board member [Marquette General Hospital Board member] that he was [suffering from] dementia and it didn't work out but all the rest have been super. I'm sort of in the middle so I know all of it. I don't know all the details. I've forgotten them but I get the gist of the whole story.

EL: Well, our problem is that you're not a medical person yourself so I'm a little apologetic there.

RMM: Oh no, no. I mean we've had that problem with all of them so when we send them back and a lot of the physicians haven't returned the transcripts and, well, we just go with what we have.

EL: You know I will do that. I will definitely proof read it.

RMM: Then we'll do an edited final copy.

EL: For each physician you're doing this?

RMM: Yeah. No, I'd be happy to do that because I blurted out a lot of personal things and I'm not sure how appropriate all of that is.

End of Tape 2 side A