

Norrie A. Thomas, Ph.D.
Narrator

Lauren E. Klaffke
Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

In 1970, the University of Minnesota's previously autonomous College of Pharmacy and School of Dentistry were reorganized, together with the Schools of Nursing, Medicine, and Public Health, and the University Hospitals, into a centrally organized and administered Academic Health Center (AHC). The university's College of Veterinary Medicine was also closely aligned with the AHC at this time, becoming formally incorporated into the AHC in 1985.

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 20th century. AHCs became not only the primary sites of health care education, but also critical sites of health sciences research and health care delivery.

The University of Minnesota's Academic Health Center Oral History Project preserves the personal stories of key individuals who were involved with the formation of the university's Academic Health Center, served in leadership roles, or have specific insights into the institution's history. By bringing together a representative group of figures in the history of the University of Minnesota's AHC, this project provides compelling documentation of recent developments in the history of American health care education, practice, and policy.

Biographical Sketch

Norrie Thomas was born in Detroit, Michigan but grew up in Rochester, Minnesota. She completed two years at a junior college in Rochester and transferred to the University of Minnesota in 1971. She earned her bachelor's in pharmacy in 1976. She worked as a staff pharmacist at Saint Mary's Hospital and the Mayo Clinic before returning to the University of Minnesota as a graduate student. She earned her master's and doctorate in pharmacy administration in 1980 and 1983, respectively. She made important strides in developing the field of pharmacy benefit management (PBM) over the course of her career, co-founding one of the first PBM companies, Clinical Pharmacy Advantage, in 1990. Over the course of her career, Dr. Thomas has held senior management positions at all of the following companies: MedCenters Health Plans, Aetna, McKesson, PCS, Eli Lilly, St. Jude Medical, Schering-Plough, and Magellan Health Services. She also helped establish the Academy of Managed Care Pharmacy. From 2009 to 2010, Dr. Thomas served as an adjunct professor at the University, coordinating Dialogues in Managed Care Pharmacy Leadership, which sought to highlight leadership within the pharmacy profession. She currently serves president and managing director of Manchester Square Group.

Interview Abstract

Dr. Norrie Thomas begins her interview with a discussion of her early life and education. She describes her early work, the systemic problems she observed in hospital pharmacy, and her pursuit of further education in Social Administrative Pharmacy. The interview then turns toward her work on pharmacy benefit management companies and the many management positions she has held over the course of her career, with special attention to her positions at St. June Medical and Schering-Plough. She reviews some problems and solutions she sees in drug development and access to healthcare. Dr. Thomas then reflects on her time with the University. She describes her experience with Dr. Larry Weaver as dean of the College of Pharmacy, her work in the creation of the Academy of Managed Care, her work with Dean Marilyn Speedie, and her work on the Dialogues on Managed Care Pharmacy Symposium. She concludes with the importance of inclusivity and the responsibility of the AHC to foster interprofessional relationships.

Interview with Doctor Norrie A. Thomas

Interviewed by Lauren Klaffke

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

Interviewed at 510 Diehl Hall, University of Minnesota Campus

Interviewed on November 21, 2013

Norrie Thomas - NT
Lauren Klaffke - LK

LK: This is Lauren Klaffke. I'm here on November 21, 2013, interviewing Doctor Norrie Thomas in 510 Diehl Hall.

Thank you for meeting with me today.

NT: My pleasure.

LK: I wanted to get started with a little bit about your background. Could you tell me a little bit about where you born and raised and your early education?

NT: Yes. I was actually born in Detroit, Michigan. My parents were living there for a time, even though my father's home was Rochester, Minnesota. Eventually, they ended up in Rochester, Minnesota, and that's really where I grew up. I went to elementary school there and John Marshall High School. Then, I did two years at the junior college there in Rochester and transferred up to the University [of Minnesota] in 1973 to the College of Pharmacy.

LK: What prompted your interest in pharmacy?

NT: It was interesting. If I look back at my background, I wanted to be a writer, a journalist. I was the editor of my high school newspaper. Originally, I was going to get a bachelor's in journalism. As I was looking over the criteria for what coursework you needed, I saw that you needed science to get a bachelor's degree. So I decided to get the hardest courses out of the way first. So I took chemistry. I fell in love with my chemistry teacher, it was a hero worship rather than falling in love, but it worked!

LK: [chuckles]

NT: I would sit in the front row and write down every word he said. I needed to take every course he taught, so by the end of two years, I had a whole bunch of chemistry, including inorganic and organic. I *loved* school.

I was the editor of the newspaper at the junior college. I don't know how this happened, but I came up against a problem and that is I hate deadlines. So, obviously, when you're writing newspaper articles you have a daily deadline. Life is full of deadlines but to have one every single day was more than I could handle.

So I went through the directory of different professions. I wanted to continue to take chemistry. I thought chemistry was just fabulous. I loved school. Pharmacy was a five-year program. I thought that's a good idea, another year of school.

LK: [chuckles]

NT: My mother was a pharmacy technician at Saint Mary's Hospital in Rochester, so I knew about pharmacy. As a young girl, I would go to work with her into the pharmacy. I loved the smell of all the drugs all mixed up. I loved looking at all the bottles. Just sitting there—of course I would be doing my homework or coloring or whatever it was; I was just there with her—I just sort of made some promises to myself that someday, I'm going to know what's in those bottles, and I'm going to know how they work. So there must have been a pharmacy brewing in me from an early, early time. I really wanted to know how did an aspirin come into you and know what to do. Was it magic? I just couldn't figure that out. I wanted to know.

So I applied to pharmacy school and got accepted even though my GPA [grade point average] was never stellar. Even at the junior college, I was maybe a 3.0, maybe 2.9. I did get accepted, but I probably would not have been accepted into pharmacy school today.

LK: It's very competitive.

NT: It's very competitive. I think the average GPA is 3.5, 3.6, so I would not have been accepted unless, of course, I'd worked a little bit harder. I've always been much more of a daydreamer. I can certainly study and meet a deadline, but I like to daydream. Really, pharmacists shouldn't daydream. They really should stay focused. That's what they need to do.

So I went to pharmacy school and immediately joined every association I could, networked. I'm a great networker. I had trouble in pharmacy school in pharmaceuticals. In fact, I remember looking at the two-volumes of pharmaceuticals, Volume 1 and Volume 2. Each one was six inches thick.

LK: Mmmm...

NT: I said, “There is no way, no way, I’m going to figure that one out.” And I did fail the course. So I had to retake it and, eventually, got it together, and graduated, and passed my boards.

I worked in a pharmacy my senior year. That was another big surprise. I guess it isn’t that surprising when you think about what happened with journalism. I started working in a hospital pharmacy, and I thought, oh, my god! This is so boring. There is no way I can do this the rest of my life, no way at all.

I immediately started thinking about what do I do next, because I do need to work. I had to put myself through college. My parents were very supportive, but they have five children and financially it just wasn’t going to be possible for my parents to support me in terms of tuition and so forth. Of course, once I became an adult, they couldn’t support me either. So working and education were clearly mixed. I needed to get an education in order to work. Things are a lot different now with pharmacy school. Clearly, the tuition after five years of pharmacy school—well, it’s actually four and four—you’re graduating with a debt of \$200,000, \$150,000.

LK: Yes.

NT: It’s huge...huge.

I ended up going back down to Rochester and working at Saint Mary’s Hospital, where my mother worked, after I graduated.

As I said, I was a daydreamer always looking at... Well, we could do this better if we reorganized or why don’t pharmacists sit at the front and talk to the patient? Why are we in the back with all these drugs? So I would give seminars about how to reorganize procedures and policies. What I noticed at Saint Mary’s working there...

[brief interruption]

It, eventually, became part of my thesis. I’d worked in hospitals in Minneapolis and the quality of care in Minneapolis really wasn’t that high. Pharmacists, in general, did not talk to doctors. In fact, when I graduated in 1976 with my bachelor’s, the law had just changed, but prior to that, it was against the law to put the name of the drug on the label.

LK: Wow.

NT: When you think about how things have changed... That is a message I try to give new pharmacy students, the rate of change is getting faster, so imagine what might change in your profession and get ready.

I remember working at Abbott [Hospital] and disagreeing with the prescribing that a physician had done. I wasn't going to dispense the prescription until I had talked to the doctor. It took me hours to find him. I pulled him out of dinner with his family and, of course, he was very upset. I said, "You can't give the patient this drug because it's going to interact in this way. I need to change it, and I need your approval to change it." I started thinking why doesn't the system help me do this? I'm a lone pharmacist sitting here trying to dispense medications, and it takes me hours to find the doc. He doesn't want to talk to me. I pull him out of dinner. It's an aggressive confrontation. In the end, he agreed, and we changed the drug. But the system didn't help me, the structure, the way we worked, our relationships. Nothing helped me to do that.

So I got down to Rochester and there was a 1,000-bed hospital, a huge hospital. What I noticed immediately is that all of the pharmacists in Rochester were so much better in terms of their clinical skills, their ability to articulate clinical care, their ability to work hand-in-hand with physicians. I thought, well I'm the same pharmacist, so why am I better in Rochester? As I started thinking about it, you had the pharmacist and the doctor and, of course, the doctor was very important in Rochester, the Mayo Clinic. But the hospital was run by nuns, at that time.

LK: Hmmm.

NT: Whenever we went to a meeting, there was always the doctor, the pharmacist, the nurse, and God.

LK: Mmmm.

NT: It was a rebalancing. It was a re-shifting. God is here, so we need to be focused on the patient, not ourselves. That's interesting to me that it's the structure that's impacting the way I can perform as a pharmacist.

I knew I was going to work the rest of my life. I knew I couldn't be a pharmacist working my shift. Pharmacy was my life. I was in the same pickle as I was with journalism. When you don't like to do the same thing every day, you really shouldn't be a pharmacist.

So I started looking through the catalog of graduate programs at the University of Minnesota, a very thick book. There was a program called Social Administrative Pharmacy. You could get a master's, Ph.D. in that program. But what I *loved* about this is that you had to pick your own curriculum. There were very few required courses. There was very little required work. It was all about what do you want to do and how are you going to put it together. When you're in this graduate program, you have access to *every* class on campus.

LK: Oh, wow.

NT: You could go to business, public health, sociology, and you will be able to take a class even though you're not registered in that particular graduate program. I was like a kid in a candy store. I can take every course at the University of Minnesota, put it all together myself, figure out my thesis and, wow! This was amazing. Now, most pharmacists don't like that much freedom and so little structure. What appealed to me was, one, I loved school and, two, I can do it. I can figure it out.

I decided to focus on health information systems and came up here and got accepted in the Ph.D. program. By this time, I'd kind of figured things out from a studying perspective. I think I did graduate with a 3.6 in graduate school. But it took me that long to figure things out.

One thing I would say about the University of Minnesota is giving people second chances, third chances, fourth chances. For me, personally, I am eternally grateful that there are these chances.

I came to the University for my Ph.D. In my reading I ran across a very, very famous professor—I'm going to pronounce his first name wrong—Avedis Donabedian. He wrote another set of three volumes, very thick, on the quality of healthcare—not quite 6 inches thick but at least three inches thick. His paradigm was that the quality of healthcare is based on structure, process, and outcome. All of sudden, I started reading him, over and over, and read all of his references—a little hero worship again—and he gave me a paradigm to explain what I had seen personally and what made ultimate sense to me.

Now, in today's world in healthcare, *everyone* is focused on outcome...outcome, outcome, outcome. I truly disagree. It has to be all three. Structure is as important as outcome. Most politicians will not agree with me. Most academic people will not agree with me. Hardly anyone agrees with me. But, once again, taking my world and what worked for me and seeing the change in how I was able to be a *great* pharmacist by changing the structure...

So I did my thesis looking at drug utilization review at the Park Nicollet Medical Center in Minneapolis and studied different methods of presenting information to a doctor and testing to see which kind of information, which structure of information produced the most significant change in prescribing behavior. There's a great story about my thesis in this book [*An Unbalanced Success: Life, Leadership, Libretto*]. In any case, I finished.

The Park Nicollet Medical Center had just started an HMO [Health Maintenance Organization] called MedCenters Health Plan and they hired me. I joined the managed care trajectory here in Minneapolis and, once again, found myself in a situation where I could impact structure, process, and outcome.

That's a long answer to that question.

LK: [chuckles] To backtrack a little bit... Do you know how long the Social Administrative Pharmacy Program had been around?

NT: It was relatively new. I would say it was maybe five or six years old. The director was Doctor Albert [I.] Wertheimer. I believe he ran up, as you would expect, against a lot of resistance, because it was such a different graduate program. He also believed in people. Many, many of the graduates that he accepted into that program did not have very good GPAs. So when you look at your GPA as the major predictor of acceptance in a graduate program, he took a lot of risks. Now, looking back, the College of Pharmacy would say that the leaders that came out of that program have influenced pharmacy practice nationally and internationally. His ability to believe in people was unusual and was also a *great* predictor, a great predictor. I think the College of Pharmacy—I've been in some meetings with them in the recent past—isn't concerned that the pharmacists that they're graduating are clinically superior, but their ability to be leaders isn't there. Some of the curriculum changes today are to make leadership a required course within the College of Pharmacy.

LK: Hmmm.

NT: I guess my recommendation is that although the clinical part and the academic part is important; very important, creating a percent of students selected based on a predictor of leadership is also important. Motivation to succeed is 95% of success; figuring out a way to find this "motivation" is important.

LK: Would you say this need for greater leadership is maybe a national trend? I would imagine that a lot of pharmacy schools are following the admission standard of GPA, GPA, GPA. Is that something that's happening nationally?

NT: I think it is. I'm on a couple of committees nationally and when you look at those people who are leaders today and backtrack, many of them did have times in their lives where academic achievement was not stellar. Many of them would tell you today that if they had applied to pharmacy school, they would not have been accepted. I also find that people who have experienced a "fabric" of life; ups and downs; have a better internal compass of compassion—which helps guide decision making

LK: I've heard the same thing about dentistry, as well.

NT: Oh, really?

LK: Yes. I've interviewed a number of dentists and they all kind of say the same thing regarding admissions and how they've seen people go on to become great dentists but in this cycle of admissions that we currently have, they probably wouldn't have gotten in. It's a really interesting trend.

NT: It is interesting. There's something we're not capturing. There has to be some sort of rebalance. In many ways, it's really the tenets of democracy. You have to reapply and

shift... Taxes really are a form of that. You take from the wealthy to give to poor. I'm not saying that's a very good idea, but there has to be a rebalance in order for the professions to have evolutionary success, really...

LK: We've been touching on leadership. I was wondering if you had any major mentors at the University either when you went through pharmacy school or during your time in the graduate program here.

NT: Clearly, Albert Wertheimer accepting me into the program and being there for me during the time of writing my thesis and finishing it. Undergraduate, there was an assistant dean of Pharmacy Affairs, Frank [E.] DiGangi who helped me quite a bit by being very, very tough on me. He, clearly, changed my life. In terms of professors and people that I would go back to, there really aren't that many.

I remember when I was thesis only. I'd finished all my coursework. I had gotten all the approvals for my thesis. The final approval was I needed Institutional Review Board approval and since I was studying doctors, the physicians at Park Nicollet Medical Center had to approve the study. It was April first, and I was presenting at their board meeting. I never bonded with my children in the womb as many women do today. I never really noticed I was pregnant, which is pretty remarkable. I just went about my business. So the baby was due April first. I'm giving my presentation and talking about regression equations and using overheads and my pointer. The boardroom was full of all these doctors. Then, I had to leave the room while they discussed it. After a period of time, the chairman of the board came out into the hallway and said, "Norrie, everything has been approved. You can go forward with your study. Now, go home and have your baby." I said, "What?" I'm more than nine months pregnant. Oh, yes, the baby. The baby.

LK: [chuckles]

NT: I had a couple of grants to finish. April 12th, still no baby. Finally around two o'clock on April 12, things started to move. What's happening now? I called the hospital to see who was on duty. The chairman of the board was an OB-GYN [obstetrics and gynecology], and I really didn't want him to deliver the baby.

LK: [laughter]

NT: I got the names. Oh, good. I said, "I think things are happening. I'll be on my way shortly." They said, "You probably won't deliver before midnight. Do you want to know who's on after midnight?" Oh, sure. Well, of course, it was him: the Chairman of the Board.

LK: Yes.

NT: I said, “You’re joking.” I get to the hospital at midnight. He’s there. “Hello, Norrie. How are things going?” “Fine.” During delivery, he’s asking me questions about my thesis.

LK: Really? [laughter]

NT: All I could imagine, one minute he’s seeing me in the boardroom and the next he’s delivering my baby. He delivered my baby. It’s interesting, because life really changes after that. I think what was so remarkable to me was that here was this person, this little girl, that relied on me for life itself. It’s a moving, moving time in your life to have that kind of responsibility. To be honest with you, everything else seemed totally insignificant. I really, really couldn’t muster the energy to even think about my thesis, finishing the work. It seemed like such a waste of time.

But I like to finish things I start, which is one thing I do. I said, “Well, I’ve just got to finish it.” About a year and three months later, everything is pretty much done. I’m taking the initial draft to my professors on my committee. I took it to one committee member and he said, “Oh, what are you doing here?” I said, “I’m ready and this is the draft I want you to review. I’ll make changes.” He wasn’t one of my main advisors. He goes, “This is amazing, Norrie. I thought you would never finish.”

LK: Wow!

NT: When you talk about mentors, that stuck with me. “I thought you would never finish.”

LK: Is it because you’re a woman who just had a baby?

NT: Yes. Maybe. Being a mother is a difficult job—he knew how difficult motherhood was, and he knew how difficult finishing a thesis could be.

LK: Hmmm.

NT: Mentors come in different ways. I’ve had mentors who believed in me, and mentors who, basically, said, “Shape up or ship out,” and mentors that didn’t believe in me. They all motivated me in different ways, all of them. Mostly because I liked to go in places where pharmacists haven’t been before, there aren’t a lot of mentors. To me, a mentor is a person that sort of helps you up the ladder or on a path. If you’re making your path yourself, your mentors are different. There are people that motivate you, but they’re not people that are preparing you for your next promotion or helping you within an organization. I’ve never been the kind of person who stays in an organization for a long period or time; although, I’ve always admired people who can. I’m the kind of person, as I said, who is sort of carving my own path, so I’m always going to a place where, perhaps, pharmacists haven’t been. So it’s a different kind of mentor.

LK: Yes.

NT: Then, one of my other advisors—I think she’s still a professor here—kept helping me and giving me chances. She was always *so* hard to please because she was so great. But we got through.

LK: Who was this?

NT: This is Doctor Läel [C.] Gatewood.

LK: Oh, okay.

NT: A very, very tough professor. As I said, she had such a high bar that I always felt like I was missing the bar.

Many, many years later, I’m on a plane coming from [Washington] D.C. to Minneapolis and it’s full of professors from the College of Pharmacy, so there must have been a meeting that everyone was at. “Hey, Norrie.” “Hey, Norrie.” I am having conversations with colleagues I had not seen for many years—very friendly! All of sudden, I’m getting off the plane, and I see Läel. I say, “Läel, hi. How are you?” She said, “Norrie, how are you?” Then, she said, “Have you finished the next book?”

LK: Ohhh.

NT: Of course, all my colleagues are looking at me. I’m thinking, oh, god, I didn’t finish my thesis.

[laughter]

NT: You always have those nightmares, you know. I think book, book, book. I had just written a murder mystery.

LK: Okay.

NT: As I normally do, I set a bar for myself and in the preface I said that it was a trilogy and that parts two and three were coming out shortly. This is all happening simultaneously. I’m thinking book, book. She goes, “I read the first one and I liked it. I’m waiting for the second.” They’re all looking at me. I’m thinking she couldn’t possibly...she couldn’t possibly mean *Death under the Oak*, a murder mystery.

LK: [laughter]

NT: I’m kind of backpedaling. I said, “Well, ummm...it’s...well it’s...you mean...” She says, *Death under the Oak*. She says the title of my murder mystery—amazing! She went on, I bought it in a used bookstore in Saint Paul. I walked in the bookstore and, all of a sudden, I see N. A. Thomas. I buy this book.” She didn’t say it was good. She

wouldn't. She goes, "I want to read the next in the series. Would you send it to me as soon as you're done?" Of course, I'm in a cold sweat. I haven't started book two.

[laughter]

NT: How could I possibly meet one of the toughest professors I've ever had and the first thing she finds out about me is, I said I would write the second and the third, but I didn't. My colleagues are going, "What is this book?" "Never mind. Never mind." Everyone knows how great Doctor Gatewood is. So when she's actually interested in something you've written, there must be something good there. She was a great mentor, too. I would have to say, though, I never did achieve the bar she set, but I certainly did try.

LK: I wanted to talk a bit about I suppose the emergence of pharmacy benefit management companies. I don't have a good sense of the timeline, but it seems like it has really exploded in more recent years. I was wondering if you could talk about your early work in that and founding and launching several companies.

NT: Sure. In the 1980s, I was working for MedCenters Health Plan. I remember the day I started with MedCenters. The headline in the [*Minneapolis*] *Star Tribune* was "Managed Care Penetration Has Achieved 20% of the Minnesota Population and It Has Reached Its Peak." Well, that was definitely wrong. We're well over 100% now. I think I was the fortieth or twentieth employee, and I just loved it.

I didn't initially start working on pharmacy. I was doing more market research for them. The big health plans on the West Coast, Kaiser [Permanente] and Group Health, at the time, were all the staff models sort of system. Group Health here in Minneapolis was that way, as well. Pharmacies were part of the building, part of the bricks and mortar of the institution. MedCenters was a different kind of health plan in that we didn't have bricks and mortar, we contracted with physicians, and we contracted with pharmacies. The same thing was happening over at United Healthcare. They were contracting with physicians and so forth.

As MedCenters became bigger, it needed organization of its pharmacy system and its pharmacy benefit. So, obviously, with my pharmacy background, I migrated into building a pharmacy system for MedCenters. There were certain elements that needed to be part of that. We never used the word pharmacy benefit. It wasn't a word. I became the director of pharmacy, so I contracted with pharmacies. I selected medications. There was a clinical component. I negotiated price with pharmaceutical manufacturers.

Once again, since we didn't physically buy the product, what was I really negotiating? So we created something called rebates. Now, in the bricks and mortar system, there was something called charge backs. Group Health was physically buying the product, Amoxicillin, but because they were a non-profit status—so were we; you had to be in Minnesota and still have to be—you would get a discount from the wholesaler for the product that you bought. You could track it, because the product, you knew 400 units and a 400 units discount, etcetera. So it was a competitive advantage for Group Health,

because they could buy drugs cheaper than we could; they had a competitive advantage when we were coming up with the premium price for our healthcare. We were designing a system of collecting the prescription information from the pharmacy, because I had to pay the pharmacies the co-payments and so forth and we had all this data. I started negotiating with the pharmaceutical companies on the backend. The charge back was on the front end. You had a discount before you bought it. I'd buy it at full price or the pharmacy does but because it's my members, I get a discount, a rebate on the back because of the volumes that I've used.

LK: Okay.

NT: United Healthcare and MedCenters were really the first health plans in the United States to create this system of negotiating with the pharmaceutical manufacturers. The reason we could do it is because we had prescription information. So both United and MedCenters created information systems to collect pharmacy data.

Then, like United Healthcare, MedCenters created a for-profit entity that began to sell management services to other clinics around the United States. I moved over to the for-profit side and began selling the same sort of consulting services to other clinics so they could develop the information system to collect the prescriptions and the negotiating ability with the pharmaceutical manufacturers. That was in 1989.

By this time, MedCenters had been purchased by Aetna [Health Management, Inc.]. I was very excited about that, because Aetna had all these members, all these people. The thought of taking the pharmacy program that we had created and growing it through all of Aetna was very exciting. I started going to meetings in Connecticut. Aetna basically was officed in a complex as big as the Mall of America.

LK: Oh, wow.

NT: Escalators going in and out. Whoa! I'm not in Kansas anymore.

LK: [laughter]

NT: I'd go to meetings and, literally, I did not understand a single word people said. It finally dawned on me that insurance companies were not healthcare companies. Insurance companies are banks.

LK: Hmm.

NT: They manage the flow of the payments for healthcare like a bank would manage checks going back and forth. They have nothing to do with healthcare. They're just banks. I presented a proposal to expand the pharmacy program within Aetna. I ran into a huge problem. The cost of processing the claim under the new system was maybe, let's just say, a dollar, the administrative cost. Aetna had paper claims and had offices all over

America with people (1000's) entering all these claims by hand and Aetna charged the employer or the healthcare system ten dollars.

LK: Oh, wow.

NT: It was probably nine dollars of profit to them. So I came in, and I said, "Forget that. Let's do it electronically and charge a dollar and make maybe thirty cents in profit." They said, "Are you nuts?" When I looked at the numbers, I said, "I must be nuts." Why would anybody transfer these claims electronically when you're making nine dollars profit on each one? There is no way you're going to make nine dollars of claim processing on my system. But you could make much more than nine dollars if you managed clinical care better, and the electronic system was the only way to create systems for clinical management

LK: Right.

NT: So I said to myself, "I'm nuts for being here."

[chuckles]

NT: Why would I want to work in a bank? So I was very, very unhappy, but I was very, very good at what I did.

So I was recruited by a number of companies and met Phil [Philip] Bredesen, who actually just wrote a book called, *Fresh Medicine*. He was the governor of Tennessee for eight years and, now, he's retired. When I met him, he was the mayor of Nashville. He had created a healthcare company and sold it. So he was sitting on a lot of money and wanted to do some investment. He said he would invest in creating a pharmacy management company, and I could run it. So I left Aetna and everyone thought I was crazy. I was a vice president. I had a corner office. Anyhow, I left it to start something new.

Still by this time the word pharmacy benefit management did not appear in the lexicon. I think it probably appeared in 1990, 1991.

LK: Okay.

NT: There were a number of companies...United had diversified. Value Health [Partners] was another one. There were quite a few forming. When you think about it, how exciting is that to have been part of something where you create a new way of delivering pharmacy care? And you actually create a new word, and that is very exciting.

LK: Yes.

NT: There's another story really. When I was in first grade, I couldn't wait to read. I couldn't wait, couldn't wait. First grade is when you learn to read. Miss Hickey was my teacher. She was very, very old. I think she was actually my dad's teacher.

LK: Oh, wow! [laughter]

NT: She was very old. She said, "This is the alphabet. We're going to learn how to read." I looked at the alphabet. I raised my hand and I said, "Miss Hickey, where are the rest of the letters?" She said, "These are the letters." I said, "No, there are more letters. I know there are so many books. There have to be more letters. So where are they?" She said, "Norrie, these are the letters. There are twenty-six of them. That's it. Sit down." I said, "I'm not going to sit down until you tell me." She said, "Sit down!" I turned to my classmates, and I said, "I will find the rest of the letters and when I do, I will share that information with all of you."

LK: You were pretty precocious. [laughter]

NT: I would go into that library and every week, I'd check out my five books. I'd just pick five books, because I knew I was going to find that letter. Eventually, somehow it dawned on me or whatever. I figured out that that is it. I'm always looking for that. Even at an early age, I want to be the person who finds a new word, finds a new letter. It's a memory I have of first grade, so it was, obviously, part of me for a long time.

LK: I saw that you talked about this in your book. I guess people ask you a lot when you're supposed to leave a place.

NT: Ohhh!

LK: It sounds like you had this moment where you were asking yourself if you were crazy. Is that an indicator? [laughter]

NT: I probably leave too soon. I don't think anyone would say I'm not persistent, because I'm persistent in pharmacy. The older I get the less tolerance I have for, I don't want to say stupidity, but the less tolerance I have for people who will not look at different ways of doing your job.

LK: Close-mindedness?

NT: Close-mindedness. We've done this this way all our life. This is the way we make money. We're not going to try something new. That's usually a sign.

I find myself in the wrong position many times. That could be because I get so excited about change, just so excited that I just jump at it. I could probably do that a little slower. As a leader, I just love change. People like to hire me as a consultant because their companies aren't really ready for change yet, but they know if they bring me, I'll get them to at least another level. It's hard to know when to leave. Like I said, I admire

people who have the management skills to stay. I don't know if it's because I wear my feelings on my sleeve, or I think I'm just so excited about building things.

LK: Being the initiator of change, it seems kind of intimidating. I saw that several times in your book where you were often the only woman, and you were saying something, and people didn't agree with it. I was wondering if you could, I guess, comment on where you find the assertiveness to make that point.

NT: I don't know. I must have some compass in me. I'm on a board of a company, and we just had a board meeting. It's a very successful foundation. It raises \$2 million a year, which is huge. We're in the process of re-contracting with our major technology vendor. Staff didn't want to go out for an RFP [Request for Proposal]. They presented a plan to do some sort of analysis market check of some pricing, very minimal, and then just renew with the current contract, current vendor. Staff presented this. There just comes a time where it's like, if I can't stand up and be proud of what I've done, I don't want to do it. My reputation means so much to me and my position and pharmacy. I'm on the board. Two hundred million dollars is a lot of money. I have a responsibility to manage that money, to be a good steward. So there was silence. The board is made up of physicians, and economists, and academicians, and lawyers. My voice was shaking, and I said, "I disagree with staff's proposal 150%." Then, I took a sip of my coffee.

LK: [laughter]

NT: The board was going to go along with the proposal. I presented my case. In my mind, I'm thinking, if I don't change their minds, I'll have to leave. I can't be part of this. It's unethical according to my "bar." There are times when you're doing good for people where you just... We give most of this money away helping people who can't afford their co-payments for very expensive medications. It's a hugely wonderful cause. But, it's still a responsibility to manage our funds the best we can. So I presented the case. The contract was a three-year contract, and over the period of three years, that would be \$50 million. It was impossible for this board to approve anything but a whole RFP, full market price check of capabilities, in addition to staff writing what the capabilities *should* be not just today but where they should be in three years, that it was a process and that we as a board demand—I used that very strong word demand—that staff go through an RFP. I said, "I want a six-inch binder of what we want, who we interview to provide the services, and what are the prices, and how we rated the criteria for our selection. One of the staff people said, "Well, if all you want is a six-inch binder..." I practically stood up again just like in first grade and said, "Don't you dare minimize the responsibility of good stewardship," and silenced him and silenced the board and, basically, then, issued an action step which *required* staff to do an RFP and got unanimous approval.

So what makes somebody do that? Part of it is it's just the right thing to do. I can't understand how my colleagues could possibly think that it wasn't. So I wanted to know why. Their main reason was we didn't want to offend our donors by instituting a new process. That's why I have to read Dominique's [Tobbell] book [*Pills, Power, and*

Policy: The Struggle for Drug Reform in Cold War America and Its Consequences. Our donors are the pharmaceutical industry.

LK: Mmmm.

NT: I will challenge that industry every minute. I'm not afraid to. I'm not afraid to walk away from \$200 million, even though it is doing a lot of good. Why? Because I am part of that industry—and we can succeed—very well—by doing things right—shortcuts hurt everyone.

LK: Right.

NT: When you take money from the pharmaceutical industry, you walk a very, very fine line.

[pause]

LK: I'm hoping my dissertation is going to be on pharmaceutical companies and corporate philanthropy.

NT: Interesting!

LK: That's really interesting to me.

NT: You should look at this. You should definitely come out to Washington, D.C. and spend some time with me and this foundation.

LK: Yes.

NT: It will open your eyes to a very, very, very, very, very critical look at corporate philanthropy.

LK: I would take you up on that if you're serious.

NT: I am serious.

LK: Okay.

NT: It's completely biased. Having said it's completely biased, I will always seek money from the pharmaceutical industry, because it's there; drugs work, they help people. But you need to be so careful.

LK: Yes.

NT: I suppose that's true though... I'm also doing some work with a global healthcare company that gets most of its money from the United States Government. That is opening my eyes, as well.

LK: The politics involved? I suppose there's politics on every level.

NT: Just the amount of money that the United States Government spends on global healthcare and the kinds of people that decide how that money is spent and what motivates the decision makers. It's so difficult to do any good in this world. It's opened my eyes to a quite... I'm not sure what I will eventually do with this information, but, once again, I'm in a situation where I'm learning a lot about the world. I think what I'll eventually do is write a paper about global healthcare and why pharmacists should be more active than they are.

LK: Hmm.

NT: The people making drug decisions around the world today, there is very little representation of the pharmacy profession. I believe that that's a negative. So that's what I'll probably do with this experience that I've created.

LK: You've held a number senior management positions, and I don't know if you want to talk about each one individually. I feel like that wouldn't be the best use of time. Are there any in particular that stood out to you that you'd like to comment on or if you want to talk about each one...I don't know how much time you have today.

NT: Is it 11:00? I have to be out at HealthPartners by 1:30, so I need to leave here no later than 12:15. That's about an hour and fifteen minutes. I don't know what the other questions are.

LK: The other questions... I ask you about a few pieces of legislation and different leadership within the School of Pharmacy here. It just depends on how much interaction you've had with them.

NT: I'll talk a little bit then. One of the positions I had and because it affects your thesis, I was the president of a subsidiary that Schering-Plough [Corporation] formed called MedAdvisor. There's times when the position is so seductive. You wait all your life to be the senior person.

I was a senior person at St. Jude Medical. A very unusual business, the medical technology world. I was helping St. Jude Medical train their sales staff to understand how to sell within the managed care environment. At the time, the device industry could, basically, charge any price they wanted, sell it whenever they wanted, because it was the physician making the decision about the device. Managed care had gotten to them, and it was no longer a physician's decision but a managed care decision and an administrative decision and their sales staff had no clue how to sell within this new structure.

LK: When was this?

NT: This was in 1996, 1997. Yes, it's a very interesting position. But once again, I didn't quite fit into the structure. It was very lonely. I like being on a team. This was very lonely. It was, once again, bringing change to an existing company.

So I got a call from the president of Schering-Plough, who I'd known for years, and he said, "We're starting this subsidiary, and we want you to be the president." Wow. How long have I been waiting for this phone call?

LK: Right.

NT: So I was seduced.

LK: [laughter]

NT: I knew that taking money from the pharmaceutical industry was a two-edged sword or a multi-faceted sword. But I wanted it *so badly*. I wanted to lead a team again. I wanted to have a passionate business, and I wanted to recreate what I'd built before and do it again better. So I did it. I think that's a lesson I've had to learn many times in my life. Sometimes I want something *so badly* that I don't see the danger signs.

LK: Yes.

NT: I'm not sure what I would have done differently.

Going into it, it was a remarkable situation. Schering-Plough was based in Kenilworth, New Jersey. Once again, a high-ranking female in a male world, but it was pretty much a failure. At the end of the day, I couldn't persuade Schering-Plough to invest in the passion of the business. They would only invest in the business because it increased sales for their products. I didn't want to be an extension of sales for a pharmaceutical company. So in the end I left. I resigned. I had a board of directors that in many cases supported the work I did, but Schering changed the board of directors without my permission to be stacked against my ideas and for Schering-Plough. It was at that point, when you're the CEO [chief executive officer] of a company and your board is against you, there really isn't any reason to stay.

LK: Right.

NT: So I resigned. Of course, they did... "You've got to stay. You've got to stay. We'll change. You can redo the board. You can do this and do that." I said, "No. It's just not going to work." They kept the company going for another eighteen months after I left. Then, they just closed it. I think what's so interesting is that we were really good at what we did. It was an early company to develop programs and services that were pharmacy driven to encourage patients to be adherent to their medication. It's still a big

issue today. No one has really cracked that nut. As I said, it was a company you could get passionate about as a pharmacist and as a healthcare person.

Our competitors had gone to Schering and offered to buy MedAdvisors.

LK: Mmmm.

NT: I heard about this after the fact. Schering said, “No.” It was a good thing I did leave, because it wasn’t going to be successful. It wasn’t even about making money. It was about, this company is going to increase sales for Schering-Plough, and that’s all it’s going to do.

I understand sales, but I also believe that in healthcare, it’s not just about selling a product. Instead it’s changing behaviors and improving care. That’s where I think a pharmaceutical company, as much as they believe all of the good things about healthcare, at the end of the day, their job is to sell their products. If there’s any legislation that should be passed, it’s to say basically that. It’s that pharmaceutical companies need to be separate. There’s a sales and marketing arm and there’s a scientific discovery arm and the two need to be separate, which is kind of leading into the College of Pharmacy here.

I am very respectful of Dean Marilyn [K.] Speedie and her vision. When you talk about what is the legacy, I don’t know what she would say her legacy is. She might say that it’s opening the Duluth campus and building that pharmacy school. I would say her legacy is the creation of the drug discovery unit [Center for Drug Design] that’s within the College of Pharmacy. I think it’s very unusual that there is a unit division, a substantial investment of resources to discover new drugs. I believe that they will be successful in bringing some of their scientific discoveries to market. The model makes sense.

LK: Yes.

NT: The university or the healthcare unit, healthcare center should be *extremely* active in the science of discovery of new drugs. The motivations are different. The motivations are, yes, you want this to get to market, and you want it to be successful, and you want it to work. Each academic person has their own bias about, well, I love benzene rings. Well, I love something else. There’s always that. But a university is motivated to discover a drug that might *only* bring in \$300 million.

LK: [chuckles]

NT: There isn’t a single pharmaceutical company today that would be motivated by that. There’s a lot of science...that \$300 million, a lot of science. I’m very proud of the University of Minnesota. I’m in awe of Dean Speedie because of her vision. I think it’s a model for policy decision making in the United States. When I look at the waste of money in the pharmaceutical industry, oh, my god...

LK: Waste in what capacities?

NT: The amount of money they spend pursuing ideas that have no chance of success. I don't know if it's the case anymore.

LK: What's the drug design model? I can't remember the catch phrase for it right now. It's not coming to me. Something like planned design or...

NT: Oh, I don't know.

LK: Okay.

NT: Having been within a pharmaceutical company, you've got highly skilled, highly successful people working on managed care issues, quality assurance issues, other issues. You look at the amount of marketing, which I know is more and more regulated now than it was when I was in the pharmacy benefit world, but the amount of money spent on trying to influence prescribing. You have all these senior executives in pharmaceutical companies who are, basically, marketing people. At the end of the day, a pharmaceutical company should be one or the other. You are a marketing company and those are the skills you need to bring to bear. And you have scientific discovery, which should be in an academic healthcare center.

LK: Hmmm.

NT: Now, a lot of people will disagree with that, but I think it's the right way to go.

LK: I'm interested then to hear your opinions on the Bayh-Dole Act and how you see this.

NT: I don't know that one.

LK: It's the act that influences drug patenting, allowing private ownership of inventions funded by the federal government, and, I may be misremembering, affects patent life.

NT: Hmmm. I'm not familiar with the actual specifics of it, but I do believe that giving patents to individuals and to organizations is a good thing to do and that it has a strong tradition. I believe the first patent laws were written, if I remember correctly, in Venice [Italy] in the 1400s. Is that true? Do you know?

LK: I think that's right.

NT: It was the city saying to the young people, "We'll give you patent protection on the ideas if they help the city." I think it's a brilliant idea, the strong tradition, and should continue. Now, should the patent protection be for five years or ten years or seventeen, I don't know. It should be for some period of time. I do not believe that there should be loopholes to that and there are. I believe Genentech has reaped the benefit of some loopholes. I don't think that's fair, but that is business—it is not fair. I think it should be

really cut and dry that it's seventeen years from this point, that you don't get an extension with a new drug design or a new drug delivery system. You don't get an extension if you add extended release.

[sigh] Having said that, I also think there's probably some disincentive needs to be given to the generic industry, because there's clearly an issue now where the generics have the power and the branded companies are not making the drug any longer. It's only produced generically and the generics can stop production, and increase demands, and increase prices. So we have that problem as well.

In general, Americans and all people—you know, self-preservation—will always try to find ways to make more money and beat the system. That's I guess what makes politics so interesting, because you solve one problem and create ten more.

LK: [laughter] Yes. The Bayh-Dole Act, I was speaking about... Part of it is that it's encouraging patenting to try and get orphan drugs to market, in particular for orphan diseases. [Correctly, this would be the Orphan Drug Act of 1983. The Bayh-Dole act sought to bring the results of federal research investments to market.]

NT: Oh, yes. Clearly, that's a positive, because it comes back to the issue of, well, if you're going to make \$300 million on a product, someone should be interested in that.

LK: Right.

NT: So encouraging drug companies to produce drugs for orphan diseases makes a lot of sense.

LK: Yes.

NT: It also makes a lot of sense for academic health centers to be incentivized to study new uses for drugs that are off patent. I think the government is certainly trying to do that with their PCORI Institute, which is part of the healthcare reform. What is it called? Patient Centered Outcome Research Institute. I do think we could do more. Just think about it. In 1990, which wasn't that long ago, I believe that every drug that was on the market in in 1990 is now available generically.

LK: Hmmm.

NT: Think of all that science.

LK: Yes.

NT: If I had to go back in time, if I still wanted some protection from disease, 1990 wouldn't be a bad year. Very successful and wonderful drugs that do great things, but we have not studied them in terms of their overall impact on healthcare. Government should provide incentives to institutions, health centers to study the uses and expanded use of

drugs when they're currently available generically. No one is. I understand the pharmaceutical industry isn't going to do it. I understand that and they shouldn't, but somebody should.

LK: Yes.

NT: I believe in patents. It's a contract that has responsibility on both sides, responsibility on the society that gives you the patent but responsibility on the side of the scientist. I think that pharmaceutical industry representation has viewed the patent as an entitlement...

LK: Mmmm.

NT: ...not as a contract with responsibility.

LK: I guess I'll switch gears a little bit here. Did you have any experiences with Larry [Lawrence] Weaver as dean of the school?

NT: Yes, he was my dean, a remarkable man and, once again, a believer. He believed in people when he didn't have a reason to.

LK: [chuckles]

NT: I think people underestimate the power that that has. When you know you're not deserving and someone of the caliber of Dean Larry Weaver says, "You will be a great pharmacist," I think 95%, 98% of the time, you make a promise to yourself that you will be. So he had that kind of power. He was a good dean. He was open to new ideas. He was the dean that supported Albert Wertheimer in creating his program.

LK: Yes, I was wondering...

NT: Not all deans would have done that. In fact, many wouldn't have. He wasn't afraid if you were successful. He wanted everyone to be successful—success wasn't a finite element in a jar; it was just unending. If someone was successful, it didn't take any success away from him. That's a very unusual quality in a person and he had it.

LK: I don't know if you had any sense of this as a student. In the Archives, there's some discussion of tension between clinical faculty and basic science faculty when Weaver was dean.

NT: I didn't see it from the academic side, but more the practitioner side, because I graduated with B.S. The Pharm.D., the clinical degree, started after that.

LK: Right.

NT: I didn't view it as tension, because I knew that it wasn't my skillset. I wasn't motivated to become a clinical person. But where the tension came in is that the clinical staff or clinical faculty was very exclusive.

LK: Hmm.

NT: They were the popular kids, and they made the rules of who could come in and who could not. I would say in general, they were very unkind to other pharmacists in this feeling of elitism. In general, with my personality, I detest elitism. I'm very *inclusive*. I probably am more inclusive than I should be, but that's who I am.

[chuckles] I was at a seminar recently...well, maybe four years ago. One of the faculty members speaking was an exclusive type of person with strong opinions of the "right way." I was in the audience, and one of the students challenged the faculty presenter and said, "Why haven't you created a national organization of clinical people that can share information and help each other in their pursuits, like Norrie did with the Academy of Managed Care Pharmacy?" Then, it just sort of blew up into a free for all, at this point.

LK: Really?

NT: I was shocked. I was shocked that people looked at what I did in that way. I am also the type of person that wants others to succeed

LK: [laughter]

NT: So it was a very brutal encounter that was not pleasant at all and certainly did not bring out the positive side of the faculty presenter.

But, in any case, it caused me to think about one of the things that I did as a managed care pharmacists is... There were about eight of us around the country doing the same thing and starting this new thing called a BBM [benefits-based management]. We wanted to start an organization of likeminded pharmacists who pursued this opportunity. So we talked to the American Pharmacy Association, and we talked to the American Society of Hospital Pharmacists, and we were rejected as not really professionals. So we went to some managed care organizations that were just starting. Then, we decided to do it alone. We created the Academy of Managed Care Pharmacy. Today, that Academy has about 8,000 members.

LK: Wow!

NT: One of the most valuable things this organization has done is, that it has helped these 8,000 people create careers of their own and have camaraderie, even though we are all competitive...

LK: [chuckles]

NT: ...but camaraderie in the sense of belonging, a sense of, we're on a mission to achieve something great. The eight of us, we were all competitive, highly successful know-it-alls, but we parked our egos at the door and said, "We are opening this up to everyone." That's very unusual. Most exceptional people try to covet their reputation or their knowledge, or their expertise; what I learned from Dean Weaver, Dr. Wertheimer, and other great people from the University of Minnesota is the power of being the best, but not being afraid to help others succeed by doing things differently, and being open to diversity of "doing." Dean Speedie is the same—I have not found this unusual trait in leaders to be common.

LK: How do go about doing that?

NT: We, as a group, had a pre-meeting around... The American Society of Hospital Pharmacists had something called the Clinical Midyear. A group in the northeast had started, let's come in a day early and just meet. So people heard about this. It started to grow. So the pre-meeting had started to grow. We had thought, well, should we just be a pre-meeting? No. We're just going to make a new organization. We're going to do it. So that's what we did. I was definitely key in making that happen. Again, I was the only woman. [chuckles] I helped people park their egos and come together.

What was your question? I've forgotten.

LK: How do you go about starting a professional organization like that?

NT: What's interesting, too, at the time, it was great that I was happy to do it. It was a lot of fun. It wasn't until much later in my career when I actually came back to Minnesota, so about five years ago, in 2008, and found that the University of Minnesota was just so proud that one of their alumni had started a pharmacy organization. I said, "Well, that's interesting." I didn't do it because of that.

LK: Right.

NT: But it is kind of interesting to think about. Even now when I give lectures to students about leadership, I say, "I was pretty much sitting in your chair, not exactly that chair, but I was a pharmacy student. I have spent my career in a branch of pharmacy that didn't exist, so my advice to you is be on the lookout, because there will be opportunities for you to do the same thing. I can't even imagine what that new profession is going to be. I can't because I couldn't imagine this, when I sat there. Something will happen. Something will change a lot, a new business opportunity, a new drug, a new something. Just have your leadership antennae out there. I want to start a new pharmacy organization. It will come to you. I don't know what it will be, but it will come."

LK: You mentioned giving leadership lectures. I know that you actually joined the University on a part-time basis for a while. Were you leading specific leadership classes?

NT: We wanted to bring managed care pharmacists back into the college. There were many ways to do that. There are so many alumni from Minnesota that have gone on to become extremely successful managed care pharmacists.

LK: Were many of them out of the program that you...?

NT: No. Now, it's grown to such an industry, but some were in the same program. I think in the city alone, there's probably over 800 pharmacists that work in managed care.

LK: Wow.

NT: Then, obviously, they're Minnesota graduates.

So is there a way to bring them back into a closer connection? So we came up with idea of creating the Dialogues on Managed Care Pharmacy, a symposium. Because of my connection with the National Academy is there a way that we could work together and create something special in Minnesota? So I did that for three years.

The first one was in 2009, I think. It was right after the, or should I say during the economic crash. Oh, my god, it was just so hard. Anyhow, we ended up losing money on that because of our arrangement with the hotel. In any case, about 150 people came and it had its beginnings.

The second year, we combined it with more of an international focus, because many of the PBMs nationally were tiptoeing into international arrangements. Of course, the University is very involved in international pharmacy. That was the second year. Then, if you remember, the volcanoes were erupting in Iceland [April 2010 eruptions of Eyjafjallajökull volcano].

LK: Oh, I don't remember that.

NT: All air travel between here and Europe was canceled for two weeks.

LK: Oh, wow.

NT: My speakers were coming from Sweden and Germany. I'm thinking, I really shouldn't do the symposium. Can they get here in time? Can they get here at all, my keynote speakers? I think the symposium was on a Tuesday or Wednesday or something, maybe it was Thursday. Sunday, they opened up air travel. So they all got here in time, which is sort of remarkable. And we made money on that symposium. It's like, gosh, can I pick anything else that would be a problem?

LK: [chuckles]

NT: So the third year was quite interesting. The Academy of Managed Care Pharmacy was having its annual meeting here in Minneapolis. I had just been asked to be the

interim executive director of the foundation. So I pulled away from my responsibilities here on campus and said, “I’m going to be in Washington to speak but let’s do a pre-meeting together.” That was like over the top successful. I always exaggerate but I think we had 200 people there. We made money, both the Academy and the University. The accolades were just over the top.

LK: Good.

NT: Then, my interim position continued. We did one more dialogues jointly in San Francisco. I remember one of the greatest compliments I got was from Jim [Doctor James K.] Marttila, who was one of the pharmacy directors at the Mayo Clinic. I think he came to all of them. After the one in San Francisco, he came up to me and said, “Norrie, I wasn’t going to come for the pre-meeting, because I thought your leadership meeting last year was so successful in Minneapolis, there was no way you could top it, so I wasn’t going to come. Then, my flights got all screwed up and whatever, whatever. I thought, well, all right, I’ll go early anyway and go to the leadership symposium. Norrie, you outdid Minneapolis.” I was just so pleased. Pharmacists are so hungry for understanding leadership. How can they do it? What can they learn?

I did another leadership conference for a company here in Minneapolis last summer, a much smaller scale, but it, too, was very successful. One of the pharmacists who has been to all of my symposiums, she came up to me, and she said, “Norrie, it is just so obvious that you are putting these symposiums together because you believe in the profession. There’s no ulterior motive. You’re not at the podium preaching. You’re not even a star of the program. You’re doing it because you love this profession. It makes a difference.”

I guess I did those a lot of times but with my push or pull to D.C., it didn’t make sense for me to continue. All things need to change. So I’m not on staff helping any longer. They’ve now given the dialogue series to [Doctor] Kerry Fierke, a professor from the Duluth campus. She’s turned it into a symposium called “Women Impacting Change” [“Women Impacting Healthcare Conference: Preparing to Lead”].” She just finished her second one. It was just over the top successful.

So you talk about change. The leadership program was successful. We were making money, making a difference, but it was time to change.

LK: [chuckles]

NT: Part of it was I was pulled anyway to a different position, but I wouldn’t have done it again anyway. It was just time to change it. There will be a time when Kerry will have to pass it on to someone else. So, once again, how do you know? Sometimes things just happen. It’s always good to think about when you end something, too, not just when you started.

LK: I don’t have the years that you were here for your graduate work in front of me.

NT: Well, let's see. I graduated in 1976, B.S., worked for two years, came back in 1978, and I believe I defended my thesis in 1982. But I think I actually graduated in 1983 then, or something like that.

LK: I wasn't sure if your time overlapped at all with Gilbert Banker.

NT: No. He had come right at the end.

LK: Right. That's what I was thinking.

Did you have any contact with Robert Cipolle when he was dean of the School?

NT: No, no, I really didn't. I know him.

LK: You mentioned Marilyn Speedie.

NT: Marilyn and Larry were the two. I don't think Gil Banker was supportive of Albert. Eventually, Albert left and there still is a Social and Administrative Pharmacy Department. It's not the same at all. It's very, very... I'm not sure what they do. They're very successful, but in a completely different way.

LK: Okay.

I know that Banker was very supportive of medicinal chemistry.

NT: Oh.

LK: Yes, that was something that was noted.

I don't know what kind of comments you might have on this just from your own experiences. There's this cultural change in the 1970s and 1980s to admit more women into professional schools, and I didn't know if you have any comment on that beyond what you've mentioned already as your experiences.

NT: Not really, except, even in this day and age... If you look at life as a bell curve, most people live under the bell...

LK: Right.

NT: ...but women forget that we're still in the first tail.

LK: Yes.

NT: When you think about it, women got the vote in 1920, eighty years ago. That's a key marker when you think fifty percent of the people in the states couldn't vote until

then. That's very key, so we're really, really at the curve. We're not even under the bell yet! I shouldn't be surprised... In my B.S. class, I think there were twenty percent women. Within the last three years, I was at some committee meeting of the College of Pharmacy, and we were talking about workforce planning, something like that. I think I might have been the only woman there. The topic was that women in pharmacy have degraded the professionalism.

LK: Really?

NT: Because women focus on their family and work part time, we've degraded the professionalism. You're just sitting there thinking, I wonder if should say something. These professors, they're all my friends, too. I've known them so long. In my early days, I might have stood up and pounced on them, but I know them all. So I was just quiet. Then, we were talking about licensing and how that's another problem because when you get a pharmacy license, it's for a state. There isn't a national license that allows you go everywhere. One of the same faculty members said, "Well, nursing has really gotten that right." When you get a nursing license, it's for the entire country.

LK: Oh!

NT: I just sort of shifted and said, "Well, I guess you'd have to say the women got it right."

LK: [laughter]

NT: *Everyone* looked at me and said, "Oh, Norrie. We're sorry. We're just pointing it out. We're sorry for our comments. We're just pointing it out." So there's always a chance to readjust, rebalance. In my younger days, I would have done it with aggression. I like it better now. When you're sixty years old and a grandma, life is just different. There's no reason to get... As I said, these faculty men are just my good friends. I love them dearly. But there's always a chance to make your mark and bring them to some sense of rebalance.

LK: It seems like it would be particularly strange being that they're your friends and colleagues but they're making these comments in front of you. Are they seemingly unaware?

NT: I think it's just... As you get older, you have trouble keeping your mask on. We all have a mask. Obviously, when you die, it's gone and you are who you are. That's why when a person dies, you can sometimes really tell what kind of person they are, because you don't have the courage or strength anymore to keep it up. Men are wounded. So you tend to blame things. You blame your problems on differences that people have. Sometimes, that's race, religion, and sometimes it's being a Democrat or a Republican. Those things come out. I know my friends; they're all different. I don't take it as something bad anymore. I just take it as it isn't me, and I'll have a chance to tell them what I really think. We have so many differences. [chuckles] I think women should

remember... Obviously, my generation, we're really on the tail. But so are you. You're not under the bell. Whatever is going to come, and I don't know what it is, some sort of equality or some sort of I don't know what, we're still in a very early stage. Be prepared that you will be challenged, because of who you are. Then, as in my book, you'll be challenged by your own perceptions of motherhood and so forth.

LK: I don't know to what extent you might have a comment on this, but both, I guess, as a pharmacy student and in your graduate work here, did you do much collaborating with the other schools within the Academic Health Center? Did you do any work with Nursing or Dentistry or the Medical School?

NT: I did, because I was in Health Informatics. But, I also got really turned on with Medical Sociology and Survey Research and just the amount of information you can gather from a survey. So Medical Sociology really was eye opening to me. If I would have known more about that, I would have probably gone there. It's just so interesting. Then, I was also in the [Carlson] School of Business, because of Management Information Systems. So I was able to... I think it may have been easier in my day to do it. Maybe it was because of Albert's program that they had to let us in. I think it's very difficult now to take a course in Carlson.

LK: I can't speak to that.

NT: I think the success of the different colleges is wonderful, but it has created barriers to getting other people. I think there is an opportunity for the Academic Health Center to always create an opportunity for a small group to break the barriers. Even if you don't believe in it, it's just good for the transmission of ideas. I don't know how the Academic Health Center is now. If they have an opportunity to create a small group of inter-professional experts who have the ability to disperse, they should do that. I think it's a good idea.

LK: Did you have any interaction with any of the vice presidents of the Academic Health Center. I mentioned Frank Cerra at the start of this project, so I didn't know if you'd worked with...

NT: I worked with Frank. I know him personally, as well. We used to go to the same church. I vaguely remember Doctor [John] Najarian.

LK: He was head of Surgery here.

NT: And, of course, the debacle of...

LK: ALG [Antilymphocyte Globulin].

NT: Was that it?

LK: Yes.

NT: That was a drug, too.

LK: Yes.

NT: I don't know if it ruined his career but it certainly...

LK: He's still around. I think he just stepped down from being head of the Department of Surgery.

NT: That's when I think Frank came in.

LK: That was a little bit earlier. ALG was in the early 1990s, like 1992, 1993, and Doctor Cerra came in in 1996. [Doctor Cerra came to the University in 1981 and became dean of the Medical School in 1995. He became vice president of the AHC in 1996.]

NT: Okay. He is an amazing leader. First of all, he's an articulate speaker. His personal approach to life is very inclusive. He's not an elitist and believes in all the professions, not just in a patronizing way, but in a true belief that they contribute. I don't know who the existing leaders are in the Academic Health Center. I do think you need someone with those qualities. I think you need someone who is inclusive and someone who just doesn't give it lip service, but has some true understanding even at a personal level of the value of the team. Frank was really the only one that I worked with.

LK: Okay.

We've talked a little bit about legislation. I didn't know if you've done any work with the State Legislature itself.

NT: I haven't.

LK: Okay.

NT: I wouldn't even know how to begin. I admire people who do know how.

LK: That kind of wraps up my questions.

NT: Okay.

LK: I didn't know if you had any final thoughts or things that you wanted to bring up that I didn't specifically ask you about.

NT: Once again, I'm not sure how you're going to use this, but somehow document and disseminate a belief that this is a Minnesota asset. This belongs to the state. We have a responsibility to the state. I think we achieve that responsibility. I think we save lives. I

don't think that the state looks at the Academic Health Center as an asset. I think they view it as a liability.

LK: Hmmm.

NT: We have to give them money, and what are they doing there? If this oral history or if any sort of effort to really create a passion within the people of the State of Minnesota, that this is their unit, and we are here to serve...if that message can be relayed... I have a license to practice pharmacy that was given to me by the State of Minnesota. I view that license and that promise with so much passion and responsibility. The state has given me something, my license, which is to protect my profession and allow me to protect it. But I have a responsibility to the state to make the profession better. I know with the College of Pharmacy and your education costing so much money, you end up with all this debt. You lose sight of the fact that you owe the state something, too. It's all about, how do I repay my debt, and how do I buy a house, and how do I take care of my family. But I think this oral history should also—[pause]—revitalize the way healthcare professionals view their oath and renew, if you will, their responsibility and their vow. It is lifelong.

LK: Yes.

NT: That's it.

LK: [chuckles] Well, thank you so much for meeting with me.

[End of the Interview]

Transcribed by Beverly Hermes

Hermes Transcribing & Research Service
12617 Fairgreen Avenue, St. Paul, Minnesota, 55124
952-953-0730 bhermes1@aol.com