Frank B. Cerra, M.D.
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

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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

Frank Cerra was born in Oneota, New York in 1943 and grew up in Worcester, New York. He completed his bachelor's degree in 1965 at the Binghamton University - State University of New York (SUNY), his medical degree at Northwestern University Medical School in 1969, and his residency at SUNY Buffalo. Dr. Cerra became a professor of surgery (1975) and a professor of biophysics (1980) at SUNY Buffalo. He also held attending staff and leadership positions at Buffalo General Hospital, Buffalo Veterans Administrations Hospital, and Erie County Medical Center. He was recruited to the University of Minnesota in 1981 to initiate the surgical Intensive Care Unit service and Surgical Nutrition Service. He served as chair of the Department of Surgery from 1993 to 1995 and Dean of the Medical School in 1995. He became Provost (the position was later renamed Senior Vice President) of Health Sciences in 1996 and again became Dean of the Medical School when the positions of Senior Vice President and Dean were merged in 2008. He retired from the University in 2011.

Interview Abstract

Dr. Frank Cerra begins part one of his interview by describing his undergraduate education at SUNY Binghamton, his medical education at Northwestern University Medical School, and his residency at SUNY Buffalo. He then describes his recruitment to the University of Minnesota, his early goals, and his growing administrative roles. He describes the leadership implications of investigations into Antilymphocyte Globulin (ALG) on the Medical School and the merging of University Hospital with Fairview Health Services. He then discusses the following topics: his interest in surgery; the culture of the University of Minnesota's Department of Surgery; his work with the pharmaceutical industry and the College of Pharmacy; his work developing a critical care program at the University; and his relationships with the hospital directors, hospital nursing, and the School of Nursing.

In part of two his interview, Dr. Cerra intersperses reflections on finances and relations among different levels of administration in the University, the AHC, and University Hospital. He also discusses the following topics: his relationship with Neal Gault; strategic and long-range planning; the goals of the AHC; the formation of University of Minnesota Physicians; the establishment of the Biomedical Ethics Center (later the Center for Bioethics) and the Masonic Cancer Center; the investigations into ALG and Dr. John Najarian; the establishment of the Center for Drug Design; William Brody as Provost of the AHC and issues surrounding faculty tenure; and the establishment of the Institute for Health Informatics.

In part three of his interview, Dr. Cerra expands on the decision to merge University Hospital with Fairview Health Services, particularly focusing on logistics, culture, and reception. He also discusses failed attempts to create a unified children's hospital in the Twin Cities. He then reflects on the following topics: the major challenges and achievements of his tenure as senior vice president; the merging of the positions of Senior Vice President of Health Sciences and Dean of the Medical School; the creation of the

Clinical and Translational Science Institute and the Biomedical Discovery District; and the medical device industry in Minnesota. He concludes by describing the University of Minnesota and Mayo Clinic partnership in research.

Interview with Doctor Frank B. Cerra, Part 1

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed in Doctor Cerra's Office in the Phillips-Wangensteen Building

Interviewed on July 31, 2014

Frank Cerra - FC
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Frank Cerra. It's July 31, 2014. We're in Doctor Cerra's office in Phillips-Wangensteen Building on the eleventh floor.

Just to get us started, can you tell me a bit about your educational background?

FC: I grew up in a very small town of 500 people called Worcester, New York, in a central school that had less than 500 people in K through 12 and had a graduating class of eighteen people.

My dad was a schoolteacher and, then, a principal, and, then, a superintendent. My family valued education very highly. On a teacher's salary, my parents were able to put all three of us through undergraduate and graduate school, which was, I thought, quite remarkable.

I went to undergraduate school at the State University of New York [SUNY] at Binghamton, which had just transitioned from being Harpur College, which was a school for people who came out of the military. It became a liberal arts school. I went there because I liked the environment. It was small, about 900 people, four years. They didn't even have graduate programs at that time; they do now. They're one of the principal research centers for the SUNY system. I went there and majored in biology, minored in philosophy.

I've got to go back a step. There was a Ph.D. biology instructor by the name of William Battin, who was very instrumental in recruiting me, I would say, in the disciplining of my mind for research.

There was another professor by the name of Mildred Shellig [-Hackett]. She was a physician who taught microbiology. Of course, I took microbiology. Then, she hired me initially to make all the growth media and, then, she hired me to teach the course. She happened to be the recruiter for Northwestern Medical School, and she thought I should be a doctor. So she, essentially, recommended me to Northwestern University Medical School, and they accepted me. At that time, I didn't have any loans.

I went to medical school at Northwestern University in downtown Chicago. I did my four years. I had to take loans out to get there. In today's dollars, it was about $100,000 for the four years.

Then, I looked around for residency programs. I finally ended up at the State University of New York at Buffalo and did general surgery there, did critical care there, and went on the academic faculty there, and started my research career. I had a role in the graduate school at the same time, because I was interested in getting my Ph.D. in some combination of biochemistry and immunology, but I never finished it. I just got too busy. I ended up doing a lot of research, generating a bunch of publications.

In between undergraduate and graduate school, I would work summers for a professor of pharmacology, Sam Mallov, at SUNY Upstate [Syracuse, NY]. That was my first publication. Of course, they wanted me to go into pharmacology. I really wasn't interested in that as a career.

After medical school, I ended up, as I said, at SUNY Buffalo and finished my general surgery trauma residency there, finished my critical care residency there, and went on the faculty. I published a lot of papers, did a lot of research, and got really interested in surgical critical care, which at that time was a very fledgling organization.

There was another national organization, the Society of Critical Care Medicine, which described itself as the first multidisciplinary approach to the care of the sick and the injured, and it was true. It was doctors, nurses, pharmacists, eventually people who dealt with ventilators, and other kinds of support people. It really began to shape my thinking about interprofessional education, so I joined that group and spent a lot of time teaching surgery students, surgery residents, medical residents, medical students, and actually developed an education and training program in critical care with the medical people. So it was kind of a joint program. I began to explore the discipline of critical care and began a major research career, which had a lot to do about supporting organs that were failing by using metabolites and biochemistry. That involved a whole new line of what became known as metabolic therapy, which kind of set the standard for the world as to how you metabolically support sepsis, and people who are really sick and banged up, and that kind of stuff.

My surgical practice at that time became managing everybody else's problems. I also did a lot of surgical procedures that right now are not common. It was operative surgery in those days and a lot of portacaval shunts, major vascular surgery, ruptured aneurysms, all open, a lot of which isn't done anymore, and a lot of just basic general surgery, which was a lot of fun. I enjoyed that.

I eventually evolved to do my surgical practice, my education and training practice, my research practice all focused on the ICU [Intensive Care Unit].

In the process of going up the academic ranks and the American College of Surgeons, I advanced into the academic surgical world: the Academic Surgeons Society, the University Surgeons, American Surgical Association, all that kind of stuff, kind of the levels of—depends on how you want to think of it—sophistication or status… It's a combination of both within the power structure of American Surgery, which was formidable at that time. It's still pretty potent at this time.

I got to know a guy from the University of Minnesota by the name of Richard [L.] Simmons. Richard Simmons has always been one of the country's and the world's top twenty academic surgeons. He was mainly in transplantation immunology, great in the operating room. He was here with John [S.] Najarian developing the transplant program, which became internationally famous and became a big part of my life in a *variety* of ways over the next many years.

They didn't have a surgery critical care program here. In fact, they didn't have a critical care program and didn't have a nutrition program. So Simmons decided he would recruit me and I came here in 1981 as, I think it was, associate professor at that time without tenure. I can't remember all of that.

DT: You were associate professor, yes. I have that.

FC: I came here and started my lab up, which was with Dick Simmons. He had a lot to do with my approach to bench research, which I ended up doing in a lot of in various aspects of organ failure, mainly with liver, using cell culture techniques and, then, did a lot of the research into how you manipulate those cells to get them over their troubles. That's where all that metabolic support stuff came from. I had a bunch of graduate students, Ph.D. students, and that kind of thing. That was a big deal to me.

At the same time I started the surgical ICU service and the Surgical Nutrition Service, which, at that time, was mainly intravenous nutritional support. A lot of the work that I did with that team evolved into the use of the gut for nutrition in both the ICU and non-ICU patients. That was better, cheaper, got better results, and, again, applied the metabolic principles to that, developed a bunch of patents, and stuff like that.

This, again, was a foray into teams, so the nutrition support team had me as a physician. It had a nutrition support pharmacist, a nutrition support dietician, actually two of them, and students. We evolved a model where we figured out what were the core skills of

each of those disciplines and what were the shared skills. It got to the point where each of these people would see consults and, then, we would talk about them as a team and take care of the problems. That's where that philosophy of mine evolved from. The same thing began to happen in the ICU, so there were probably fifteen or twenty research protocols going on in the ICU at any one time, so I evolved a research service and a clinical service. It ended up with Joanne Disch, who was chief of Nursing, developing the first team model of critical care of the primary care nurse, the critical care doc, and, then, the pharmacist, then the respiratory therapists. Then at the end of that, when I finished doing that, around 1990, we would have the patients' families on rounds. We involved teams. We would see the patient together. We would discuss what needed to happen. We would write the orders until I brought in the electronic health record in the late 1980s, early 1990s. Then, we did it all on that. That was the first national team model of interprofessional care.

It soon got picked up by the Society of Critical Care Medicine. They made the transition from a multi-professional to a true interprofessional training. There's a lot of studies going on now as to what's the current status of that model? Is it going backwards? Forwards? I honestly don't know, because I've been out of it for twenty years.

The other point that happened there is that the usual model of critical care is that the attending who admitted the patient to the hospital was the attending physician in critical care. Then, there were a thousand consultants. The critical care model was that a trained, certified, critical care physician would take over the care of those patients with that team. I had to make the transition in this bastion of individualism of this Department of Surgery. It took a few years, but, then, people began to see better results. People got out of the ICU. They got out faster. It was cheaper, and we still kept the primary team in the loop on what was happening. They made the major surgical decisions but we took care of the patients. That was the beginning of surgical critical care. I had one of the first fellow training program in the country and helped establish the specialty boards in critical care. So that was that part of my life.

Then, as I moved through that, I was pushed, pulled, dragged, kicked, however you want to say it, more and more into administration by the Hospital, by the nurses, had greater and greater levels of responsibility for medical care and, then, the basic policies of the ICU and, then, of course, all the problems that went with it. The same thing began to happen in the department. I'd become responsible for education and that kind of stuff.

Then, in the early 1990s, the big ALG [Antilymphocyte Globulin] fiasco came. The chair, John Najarian, was essentially moved aside by the president of the University [Nils Hasselmo]. How that was done had a great deal to do with the feelings of health sciences about Morrill Hall, because there was no discussion. The president came over. A department meeting was called. What was it? February 12, 1993, I think was the right date. I can tell you where I was sitting in the room. Nils Hasselmo got up and said, "Your department head is no longer your department head, as of now." He was just put in limbo while this investigation is going on. By then, it was all over the papers.

Ed [Edward W.] Humphrey became the interim chair. He was the chief of Surgery at the V.A. [Veterans Administration], a *very* capable guy. He was a really good administrator, but he wanted it as an interim basis.

Then, there was a search committee and Shelley Chou, who became the dean after David Brown was forced to step down as part of that whole ALG story, asked me if I would become the chair of Surgery. That happened in October 1994, I think. I get a little confused on the dates. So I did that. I began to change the department from a vertical decision-making structure to a horizontal inclusive decision-making structure.

After about nine months, Shelley Chou retired and they had a search for a dean and I was asked to become dean of the Medical School, which I did. Bill [William R.] Brody was the provost for health sciences. Then, Bill Brody decided he wanted to be the chair at [Johns] Hopkins. At that time, we had a three-provost system.

So what was going at that time was, of course, the federal lawsuits over ALG. Bill Brody had initiated a program that was the Champy reengineering model [James Champy and Michael Hammer, *Reengineering the Corporation: A Manifesto for Business Revolution*] where you would throw out school identities, deans, and you would establish affinity groups, take a blank sheet of paper and redesign everything. It didn't go over well. Then, he wanted to get rid of tenure and that was his first speech to the faculty. He convinced the president to go to the Legislature, and I think it was $5 million of funding, and they were going to get rid of tenure. There were a few people on the Board that thought that was a good thing to do. Then, in the middle of that, he left. The faculty was revolting. They were going to form a union. So I had the ALG thing and the union. Bill Brody left in the middle of selling the Hospital. I had to finish that up. And there was no direction as to what was going on. And Hasselmo was leaving. And it was a mess.

So for some reason when Hasselmo called me, I said I would do it; I would become provost. I think it was because I looked at this and said, "This is a critically ill patient."

DT: [laughter]

FC: I also had figured out at the time… There's another piece… While all this was going on, Roby [C.] Thompson was head of University of Minnesota Clinical Associates and then what was called the Minnesota Health System, which Greg [Gregory] Hart actually led, which was part of the evolution of the Hospital, which was under the Regents control, to move into a position where it could be more flexible and nimble. But at the time, there were eighteen different practice plans in the clinical departments ranging from not-for-profit to for-profit, which was kind of bizarre. So we knew we needed to get rid of that. I was put in charge of developing that new practice model. Then, when I became dean, Steve [Stephen J.] Haines, the current chair of Neurosurgery, took that over. But it was implemented the same day we implemented the sale of the Hospital to Fairview [Health Systems]. So we sold the Hospital. We did not sell the practice plan. We kept the practice plan. We kept our controls over education and research. That was the beginning of that relationship in 1997 on January 1.

DT: Was that when the Health System came together with the Clinical Associates?

FC: No. What happened is the University of Minnesota Health System and the University of Minnesota Clinical Associates got rolled into the University of Minnesota Physicians [UMP] plan.

DT: Oh, okay.

FC: We sold—actually merged it with Fairview—the Hospital at the same time. So that's how we got Fairview, University of Minnesota Physicians, and the Academic Health Center.

Then, for a time, I was both dean and v.p. [vice president], which was kind of crazy. I still think it's crazy. What you're saying is the chair of a billion dollar organization, the CEO [chief executive officer], is also the CEO of another 800 million dollar organization composed of many different disciplines on a platform that has to manage education, research, and clinical practice. That's too damn much work for one person. I did it for about nine months.

Then, I recruited a dean, which was Al [Alfred] Michael, and I just focused on senior vice president and had the job of rebuilding a destroyed organization. I talk about this in the context of your question, because it's all part of my education.

DT: Sure.

FC: I had to pick up a lot of stuff on the fly. Some of it I took in school. Some of it I just learned online. Some of which I found is good surgical training. It trains you for a lot of things.

[chuckles]

FC: You do all kinds of stuff on limited data.

At that point, Terry Bock, who had been the deputy administrator for the State of Minnesota, took a sabbatical with Bill Brody. So when Brody left, and I became a senior vice president, I asked Terry to become my chief of staff. Then, I recruited a chief financial officer, and, eventually, a head of Education, which is still Barbara Brandt, and, then, a health attorney. The attorney didn't report to me. It reported to General Counsel, but was positioned in my office. That became the core team that developed the Academic Health Center along with the Dean's Counsel, which was comprised of the deans of all the schools, and evolved this into the Academic Health Center of which there are only a couple more in the country. It was really the envy of the country, because of what it was accomplishing. Getting through that, which is a whole other story, was how do you start it? In the midst of all the tension, I just started a series of open meetings to let people really vent and find out what was on their minds. There are tapes of those.

DT: Oh, there are?

FC: They're over in the Academic Health Center. When the communications people left and that was reorganized, we brought them all over to the Academic Health Center. You can ask Terry for them. He and I and a few other people watched them on the last day I was here, some of the tapes of those open meetings. They were very contentious. [chuckles]

It taught me a lot about working with angry people, about what's on people's minds. How do you find out and how do you begin to move them in a different direction? I chose a model that really asked five core questions. We can go through those at another time.

DT: Sure.

FC: Around that, I built a process that was led by Terry and a very senior professor, Marty Dworkin, who is now dead. He died of a stroke about a year ago [on February 6, 2014]. He was a microbiologist, very respected by all of the faculty. They led an effort that had two levels. We put together teams inside each school, and they developed answers to the questions. Then, we shuffled all the teams and made them interscholastic and did the same exercise. Out of that, we extracted a strategic plan.

Part of what I had done is, I said when I became senior vice president, "I really need my own faculty governance system. It's not that it needs to be separate from the University's, but I need to work with them." That was set up. It was actually another student consulting group.

This strategic plan, as it evolved and when it was formed, went through all of the faculty committees in all the schools and, finally, up to the University and was the 2000 Strategic Plan, a major piece of which was interprofessional education. That's when I knew I needed to get an Office of Education established…several years earlier but the place wasn't ready for it. Then, they finally figured out they needed it. The Office of Research, everybody figured we needed and that was the breakthrough in moving interdisciplinary research. If you look at the U's research portfolio, that's where the growth was. It was all in the interdisciplinary fields.

Out of that was the rest of the evolution—I'm kind of skipping across the top here—of getting high performance teams, getting the resources, eventually moving into the biomedical discovery district, moving IPE [Interprofessional Practice and Education] ahead, getting better coordination between the practice plan and Fairview. It ended up in this discussion that UMP and Fairview and the University needed to form a vertically and horizontally integrated health system. We worked very hard on that. The Board of Regents was moving with it, but we could never get to an agreement with Fairview over governance, and decision-making, and, believe it or not, use of name.

DT: Really?

FC: Yes. That was bi-directional, because by that time, there was a big movement on the Board of Regents over branding. It came from the Mayo influence. But we knew from the marketing studies that the real brand was the University brand. This was when David Page was the CEO of Fairview, before Mark [Eustis] was. He and I changed the name of the Hospital from Fairview University Medical Center to the University of Minnesota Hospital-Fairview. The way the agreements had been set up, that could happen on David's signature and my signature.

Then, we had this big donation for the Children's Hospital. How we got to that is a whole other story because of the failure of getting a unified children's hospital in the Twin Cities. The donor wanted this to be called the Amplatz Children's Hospital. At that time, I went and talked to the president, members of the Board of Regents, the General Counsel, and they all said, "Yes, that's fine." But after that, the Regents said, "We need to take control of our brand," and they began to redo the whole thing so that we could never really move the integrated system concept ahead. Then, there were always these discussions of how do you share leadership between the executive branch and the provider branch that you need to have a successful organization. The executives who were trained in the old vertical model viewed that as a loss of control. They're very vertically oriented. The University's model is a distributed model. So I had distributed a lot of authority, which were all defined, the roles and responsibilities—the deans to department heads were part of the annual review and alignment process, which, again, is a whole other story about how that functioned. How do you get to be a high performance team? That fell apart after I left the position in 2011.

Along there, I had worked with Bob [Robert H.] Bruininks [University of Minnesota president] who was my old friend. At that time, he said, "We need to do some succession planning. Here's what I'm doing." I said, "Here's what I'm thinking." At that time, I had been at this about fifteen years. I said, "You know, I'm not getting any younger here." [chuckles] I set out a work plan for what I wanted to accomplish, and I said, "I'm going to step down December 31, 2010," which is what I did.

Now, originally what was supposed to happen is Bob was supposed to step down before I did, so there would be a new president to help recruit a senior vice president. But, the Regents changed all of that.

DT: [chuckles]

FC: They just took control of the whole thing.

Then, a consultant was brought in, actually by Bob, to say, "Do we really need to restructure the Academic Health Center," and that's where the idea of the permanent v.p.-dean came in. Of course, I had to do that the last two years. I spoke violently against it, because I think it was wrong, and I still think it's wrong. It just doesn't work well. You can't have a medical school that you want to be top rate and an academic health center to

be top rate and have one guy at the top. It doesn't work. I think that's what's playing itself out.

So that's my longwinded educational answer.

DT: [laughter] That's actually good because it gives a really nice overview, so it's actually good for me to plug in then.

FC: [chuckles]

DT: Why did you focus on surgery? Why did you go into surgery?

FC: Oh… That's an interesting question. When I was twelve years old, I was in gym class. We were playing kickball or kick the can or something and I got kicked in the flank—by a girl, none the less.

DT: [laughter]

FC: It put me out. Two days later, I started hemorrhaging in my urine.

DT: Hmmm.

FC: After all that workup, I ended up having a congenital anomaly in both kidneys. The drainage system was constricted. It had ruined my right kidney. At that time, they had just figured out a surgical procedure to fix this problem. I had that on my left, and I've been fine ever since. But that experience convinced me that I ought to become a surgeon.

Here's the interesting part… When I was applying to undergraduate schools, I was accepted into a slew of them and one of them was Holy Cross in Massachusetts. When I went there with my dad, they worked you over. You met a lot of people. You took some exams, did all this stuff, and, then, you had a conference with them. I said I wanted pre-med. They said, "We don't think you should do that. We think you should be in business."

DT: [chuckles]

FC: Interesting.

DT: Yes.

FC: I said, "No, I want to go to medical school." Well, they were right. It took a long time to figure it out, but they were right.

[laughter]

FC: That's what, to me, makes it kind of interesting. I kind of figured it out as I went along, and I moved more and more to administration. I think that was kind of the subconscious movement of finding out that you like that kind of decision making, and the higher up you go, the more and more you can shape and frame what's going to happen, which is, ultimately, why I took the job as senior vice president.

[laughter]

FC: I figured it was a chance to just reshape. That's where a lot of the stuff that came to fruition came from and is still operative today. I'm a little disappointed in some of the subsequent movement that's occurred. We can talk about that. I think this institution and most academic institutions are not looking downstream far enough at the changes that are happening in healthcare and its impact on the health professions. When you've got a medical school where fifty percent of its budget comes from the clinical practice and you're not doing that, you've got a problem—and they're not doing it. They're more into this short cycle, not rapid cycle but short cycle stuff. We can talk about that, too.

DT: Yes.

FC: That's where that came from. I enjoyed operative surgery. I really enjoyed doing it.

DT: So you had the best of both worlds. You got to be a surgeon and, then, you got to do the administrative part.

FC: Yes.

DT: What was the culture in the Department of Surgery like when you arrived here?

FC: It was wonderful. [laughter] You couldn't find a better boss than John Najarian. He just knew who you were. He knew what you wanted to do. He met with you. He would work with you and say, "Where do you want to go? What do you want to accomplish?" I would tell him that, and he would just make it happen. I never understood where all the money came from, but my practice was doing well, and he was supporting my research. I was beginning to get NIH [National Institutes of Health] grants. I always had about half my portfolio NIH and about half private sector, because I like working with drug companies and that kind of stuff, developing new products.

At that time, you were a major player with the drug companies. I refused to just test their products for them. That has no value for me, and it really has very little academic currency. Yes, you make money at it, but I wasn't worried about that. But I would come up with ideas and, then, they would pay to develop them, and we would get a new product that had real meaning. That, I liked to do. I considered that legitimate. It was before all the conflict of interest stuff. Do I believe there was a need for all of that? You bet I do. I saw it in action. I lived it. That became part of my portfolio.

In fixing the research enterprise, [University of Minnesota President] Mark [G.] Yudof made me what he called the czar for research redesign, which is what I did with another team. Out of that, I was asked to lead the development of what is now the Compliance Program. That's another sidelight, which I enjoyed.

Along with that came… The OSHA [Occupational Safety and Health Administration] stuff was in shambles, so there was an OSHA Committee. Then, the asked me to develop the OSHA Program, which I did.

Then—these are all little sidelights—our health insurance was with the state, but it's getting hellishly expensive, so I led an effort to self-insure the University. I think it was in 2005 or 2006. I led that for a long time with a group called the Administrative Work Group. We set up the committee of faculty, P&A [Professional and Administrative] bargaining unit, and civil service. What did we call that group? Employee Advisory Committee. It was a consulting group with teeth, and that's how we got to the system we have today. So that was another sidelight.

I finally quit working on that about four years ago. I said, "I don't want to do this anymore."

DT: [chuckles]

FC: I've forgotten what your question was.

DT: I'd asked about the culture of Surgery.

FC: Oh, yes. The culture was one of highly valued academic productivity and clinical prowess. So when I came here, I had to prove I could operate as well as anybody else. That's the machismo, and I did that. It was fun. Once they kind of accepted you, you were able to do all these other things that we talked about. It was a great department. We used to meet all Saturday morning, have grand rounds, work your butt off, but the chief always was there supporting you.

And, then, this fiasco came, which I think could have all been prevented. That's another story. [sigh]

DT: Yes, we'll get into that another time.

FC: The tone of the department changed. When I was interim chair, it usually happened around Wednesdays, the federal subpoenas would come, and I had to deal with this. It became an ugly environment with federal marshals and all that kind of stuff. That happened.

DT: Going back… You said you were working with drug companies and you were doing drug work. Did you have much collaboration or any collaboration with the College of Pharmacy?

FC: Yes, I've always collaborated across schools and disciplines, whether it's engineering if that's what I needed with the artificial liver or pharmacy because of some of the cell culture work. I was very interested, and they had some experts in Cytochrome P450 and the liver. Then, of course, I worked closely with the College of Pharmacy in the Pharm.D. Program to train critical care pharmacists. I actually had a joint appointment in pharmacy—still have—for years and years and years.

DT: Yes, I saw that.

FC: I really liked that. Part of the history of that is, when I was in high school, I had a full-time job in a pharmacy, retail. I learned the retail business in this town in which I grew up. I used to work with them, and fill prescriptions, and do all that kind of stuff. It was fun, but it wasn't what I wanted to do with my life.

[chuckles]

DT: I had a part-time job in a retail pharmacy in high school.

FC: It's fun.

I learned the value of multiple disciplines, but I missed one. Public health. I didn't realize there was a School of Public Health here until probably five or six years after I'd been here…

DT: Oh, wow.

FC: …or what a school of public health did. Gradually, I began to interact more with them in certain areas, mostly research. Research is the bridge for most things until interprofessional education and clinical practice really came along.

DT: When you were developing the critical care program—you mentioned starting this surgical ICU—was there any connection with the medical ICU? Was that up and running at the same time? Were there any parallels between what you were setting up here and…

FC: Initially, no. They didn't have an ICU service.

DT: Okay.

FS: It was done by the chief medical resident who did everything. They saw the surgical ICU service. They, then, recruited Pete [Peter B.] Bitterman as head of Pulmonary, who was also certified in critical care because the pulmonologists had moved in that direction. Initially, there was a lot of tension around it, but Pete and I got to be good friends, and we worked out relationships about each other, who was doing what. I would do bronchoscopies, and he would do bronchoscopies. We just developed these relationships. He knew when I called him I was in trouble, and I knew when he called me he was in

trouble. I began to incorporate them into teaching the surgical residents. They eventually started a medical ICU and developed, you know, Dave [David H.] Ingbar and another group of just topnotch critical care pulmonologists. Then, when I moved into administration and Greg [Gregory J.] Bielman took over the surgical critical care program, they, eventually, made it one program. It's not only one program; it now does most of the critical care in the Twin Cities: Southdale, the Ridges. That really blossomed. It's done very well. They still have a very active fellowship program

Another controversy was should there be general ICUs, or should there be neurosurgery specific ICUs, or cardiac surgery specific ICUs? We finally sorted that out by saying, well, what do the patients need? A routine coronary bypass doesn't need an intensivist. They're usually out of the ICU within twenty-four hours. When you start getting organ failures or sepsis, that's something else. We worked it out on that basis.

The guy who started critical care at the V.A., that's Rob Barcke who was one of my fellows. My partner was Jerry [Jerome] Abrams. After I became dean, he moved to the V.A. and is a general surgeon intensivist. I must have trained oh, 100 fellows who are all over the place now.

DT: So this was one of the first surgical intensive care units. Did a lot of your fellows then go out and start programs elsewhere?

FC: Yes.

DT: That's fantastic.

FC: Yes, and I still hear from them.

One of them Richard Barton moved to Utah after he finished his fellowship here. He developed their ICU service, became the core of what's the Utah Trauma Service, got a lot of laws passed. I just reconnected with him about a year ago, because he was up for promotion and tenure. I think they've done well.

Another guy John Mazuski I trained who also got his Ph.D. degree in biochemistry, partly with me, partly with a biochemist, went to Saint Louis and had the same history.

It was a lot of fun, a lot of work but a lot of fun.

DT: How much interaction then did you have with the Hospital director? I guess John Westerman was just finishing up when you got here and, then, Ed [C. Edward] Schwartz, I think, took over from him.

FC: Not with them a lot…Ed Schwartz, Bob [Robert] Dickler. Actually, Keith [A.] Dunder, the health attorney now who resides in the Academic Health Center, I met when he was Hospital attorney. Then, I worked it out with Mark [B.] Rotenberg…because Keith really wanted a focus on health sciences legal issues, of which there's a very long

list beyond malpractice. That's where he came from. So I knew the Hospital administration very, very well. It was a struggle because they were trained in the model where physicians are the enemy. They just felt that way and really didn't want the docs to have much influence outside of the medical staff model—in other words not inside their tent. It's very different now, but I fought a lot of that battle, too, because they just ignored what the patients needed, and they ignored what was going on in the marketplace. The market share, which was never very high, seven, eight percent, fell to five, six percent. The Hospital was going bankrupt, and these guys were still charging the same hospital-base fees as they were. The managed care system said, "We ain't paying for education. We ain't paying for research. There's no reason cholecystectomy your hospital should cost any more." That was the big issue, and they didn't want to change. Part of that wasn't all their fault in the sense that the thing was under the Board of Regents for a long, long time and nothing moves fast when you're under the Board of Regents. I served on the Hospital Board for a while. Finally, they got control over HR [Human Resources] and contracting. It was almost too late.

Now, having said that… When Brody was here, we were talking about what are we going to do with the Hospital because it can't go like it is, we looked at, well, do we turn it into an NIH-type research hospital? We costed that, did a business plan. No, you can't make it work. Do we close it? Well, there was sentiment for that in the community because they said, "That's the Harvard model." It really isn't. In the Harvard model, if you're at the Brigham, that's all controlled by Harvard. It's not controlled by Brigham and so on and so forth. There was no way that was going to happen at Allina [Health]. So we said, "Let's find a partner." That's another story. It's probably too long to go through now. We finally ended up with Fairview, because we shared a lot of common values, and that's basically where that came from. It turns out that was a little overstated but, nonetheless, that's how it got the way it got.

DT: How about with the nurses and the nursing service in the Hospital, especially when setting up your critical care program? How were relations there?

FC: My relationship with the nurses has always been excellent. I figured out right away they knew a lot of stuff I didn't; the same for the pharmacists. I learned also right away in dealing with very sick patients, they need a doc in the beginning because of the depth and breadth of knowledge and experience in decision-making. But after three, four days, most patients are either dead or they're stable, and I figured out the nurse could do a better job taking care of that patient than I could, especially with the pharmacists and respiratory therapists. I went on rounds. I voiced my opinion, but we developed a joint care plan that encompassed all the disciplines. So I never had any issues with Nursing. I've always found them to be easy to work with. They add a lot of value, a very different point of view than mine, a very different mental model. The same with pharmacy, a very different mental model, but very essential.

Then, I always supported the development of what then was called primary care nursing and, then, became nurse practitioner. The idea of the nurse practitioner actually came out of trauma. The trauma nurse practitioner showed its value. Then, we had critical care

nurse practitioners. Then, I helped Connie [Delaney], when I recruited her here, put through the DNP [Doctor of Nurse Practitioner] and simplified the nursing training program.

I believe so strongly in that; I helped guide my daughter [Christa Cerra] to be in the DNP. She's got her DNP degree.

DT: Oh, wonderful.

FC: They have a major role to play, a lot of politics with medicine, etcetera, but that will work itself out.

DT: Did she do the degree here?

FC: Yes.

DT: That's wonderful.

I think it's close to one o'clock. You said you have to leave…

FC: Yes, I do, actually, today.

DT: Maybe we should wrap up and pick up…

FC: Yes, let's see what next week looks like.

[End of Part 1 of the interview.]

Interview with Doctor Frank B. Cerra, Part 2

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed in Doctor Cerra's Office in the Phillips-Wangensteen Building

Interviewed on August 4, 2014

Frank Cerra - FC
Dominique Tobbell - DT

DT: It's August 4, 2014, and I'm back with Doctor Cerra in Doctor Cerra's office.

I was wondering if you could tell me a bit about Neal Gault as dean. He was dean when you arrived and for several years, until 1987, I believe.

FC: I got to know him reasonably well from a variety of points of view, as a faculty member, as somebody who was setting up programs in the Department of Surgery, as somebody who was getting involved in education, all that kind of stuff. I always found him to be a really good dean. He was thoughtful. He was open. He listened. You could go in and talk to him. He would put together a thoughtful response. He just knew how to work with people. He was good.

It was also during that experience that I figured out that the mode the dean's office operated in was a very narrow vertical system. There was one business manager who, basically, put everything together and nothing happened until it went to the dean. The result of that kind of thing is slow progress. It's not that there weren't meetings with the department head or the faculty, but mainly the year revolved around budgets, and accreditation, and recruitments. There really wasn't a major strategic direction and goals. There were a couple of exceptions.

That was the era of the clinical department kings, and I think that made it very difficult for the dean—it was, basically, a weak dean system—to do much. Frankly, I don't think that's a whole lot different today, because I don't think there's a strong vice president for that to happen with. When you have split the academic reporting functions from the vice president, it's very difficult to make that happen. I think you know you pay for your sins, so to speak.

Neal was very well connected with the community. He was very well connected in the international scene, particularly South Korea. He had a *marvelous* history of development in South Korea, involvement in World War II. He was just a very good man. That's my summary of Neal. I really liked him. Actually, we kept in contact for a long time until he died [on December 11, 2008]. We would see each other at breakfast at a place called Zumbro Café [Minneapolis, Minnesota] on Saturday mornings. [chuckles] He added a lot to the culture of the Medical School in a positive way.

DT: I'm glad that you brought up strategic planning, because the late 1970s, the early 1980s right when you arrived was when long-range planning was ostensibly introduced into the health sciences. It coincided with retrenchment and budget cuts across the University, but including in the health sciences. I wonder if you encountered any of that kind of attempt to begin long-range planning in the health sciences.

FC: The short answer is no, for a variety of reasons. At that time—how should I say this?—the senior level of administration in the Academic Health Center really was poorly developed. Yes, there was a University–wide effort, and there was an effort to get rid of the Dental School and get rid of the Vet [Veterinary] School. There was a human cry and outrage, and it all went away. It just didn't go anywhere. The strategic planning that I saw was whatever the department head wanted to do and whatever the clinical chairs

decided they wanted to do, that's what got done. There was very little interaction with the other schools in health sciences over almost anything.

The only real interaction that occurred was progressively on the faculty level, as the NIH demanded more and more interdisciplinary, interscholastic research. Then, faculty would seek out faculty, and they would write grants. So that was kind of the first place that this interprofessionalism crept in for survival to retain your rankings, because medical schools were, and still are, ranked by the amount of NIH money they have, even though NIH doesn't want it that way. There really wasn't a premium on education. Everybody thought they knew how to educate the next generation of doctors and did it the way they were taught. You know, "See one, do one, teach one." Try and do what you think is mentoring. But there really were no professional educators involved. It just perpetuated the same Flexnerian model that had been in existence for years and years and years.

I don't want to sound pejorative about that. I think at the time, it accomplished a great deal in an era when the big pieces were in place to accomplish a great deal. So what are those pieces? Well, Medicare and Medicaid were now paying for patients that used to get free care. NIH was pouring tons of money, at that time in the late 1970s and early 1980s, into facilities and, then, into research in small grants, big grants, so there was plenty of money around.

Private practice was gangbusters. Even though the then group health was offered to the University, the clinical chairs turned it down. Of course, that ended up as United Health Group because they said, "We don't need that." At the same time, the family practice program wanted to expand and there was this legislative mandate for it to expand along with the Rural Physician [Associate] Program. But the clinical chiefs didn't want them, basically, admitting to the Hospital.

So to survive, they evolved a network of practices of their faculty contiguous with, essentially, other hospitals in the Twin Cities and admitted to those hospitals, the result of which long term was we had no real primary care base to feed the specialist and sub-specialist system when the managed care market said, "We're not paying for education. We're not going to pay for your research. You're going to have to compete like everybody else in the community," and the clinical system said back, "Yes, but there are certain things you can't get anywhere else," transplantation, that kind of stuff. Well, that began to change. The biggest cardiac piece ended up at Abbott [-Northwestern Hospital]. People began to do kidney transplants. They became routine. This is the standard cycle of what happens: new innovation in the medical school and, then, you train the next generation, and you send them out into the community, and they begin to build up the community, and then they compete with you, and, then, they take that over, and it becomes routine. You have to rely on continuous innovation.

You put those together, and it was the biggest expansion in both basic and clinical science research across the country. It was just this *huge* expansion. Money was plentiful. If you needed something, the department head would get it for you.

What happened, for instance, in the Department of Medicine is a good example where they put a premium on promotion with or without tenure on having NIH grants pretty much as the sole criteria. So the good clinicians who were attracting large volumes of patients left, went to Hennepin [County Medical Center], went to Park Nicollet, went other places in the community. You built up your competition, and this is where the big private practice group came that's currently at Abbott and Health Partners. So it's this turmoil of that cycle. Innovation couldn't happen fast enough for that to happen.

Then, there was another phenomenon that happened: the endoscopic revolution. That didn't start in an academic health center. It started with endoscopic gallbladder surgery and it started in a small hospital in Scranton, Pennsylvania, a small private hospital.

DT: Hmmm.

FC: The guy's name, I can't remember. He developed the technique. He's the one that started training everybody.

Then, it moved into the academic health centers and began to get developed in other areas. It's an *applied* skill and there was so much going on in the community with well-trained surgeons, for instance, and well-trained gastroenterologists, et cetera, that they just took that and applied it.

Voila! The edge of the University became reflected in its shrinking margin and its shrinking market share. All this stuff is connected. Then, it became clear that the king model simply was not going to survive under the managed care movement, and the changes that were happening in health care, just too expensive. The pride of the medical school showed through. The pride of the University showed through. The relationship with the community was not good.

One of the reason's we have two children's hospitals is because of the lousy relationship between Pediatrics and… You've heard about this story. We could never overcome that. I tried, during my tenure, I think it was three different times, two with Al Michael and one on my own. I couldn't make it happen because of market forces—let's just say that for now—and the underlying animosity with doing anything that was good for the University and, at that time, the University with Fairview.

All that stuff just progressively came to fruition. It's one of the reasons the Veterans Administration is way out there and not here on campus. It's one of the reasons that the new University Hospital when it was built…there wasn't consideration given at the same time to moving the dorm quad to make room for obvious expansion that was going to happen. It's why we have two campuses now on the Fairview campus. It's all of this shortsighted—I'm still keying on your strategic vision and plan—non-long-range vision and plan and a very high turnover of leadership. Tension developed and, then, ALG just fed that, the Hospital going south financially just fed that, the attempt to remove tenure by the then provost just fed that flame and it just blew up—not unexpected, I might add.

DT: [chuckles]

FC: Those of us on the front line, we weren't playing up in the ether. We never saw it. For instance myself, I wasn't that much involved outside of my own sphere of lab and practice and research. I was just beginning to get involved in the higher levels of administration and beginning to understand the health marketplace and what was going on and the same with a lot of the other leadership that was emerging. The powers that be didn't want it to change. When the new dean came, he didn't want it to change. He didn't want to deal with it. I suppose that's not the right way to say that. There was a reluctance to deal with the forces at hand or some phraseology like that. That was the basis of the whole ALG mess. That started that ball rolling.

DT: Several other things that you touched on, the idea of the fiefdoms that the department chiefs had, the lack of interprofessional education in particular. Those were the things that the creation of the Academic Health Center in the 1970s was supposed to dismantle, those fiefdoms, to kind of do away with or at least minimize the hierarchies within the health sciences…at least minimizing it so the Medical School at the top of the hierarchy and was premised on the idea of the team concept.

FC: That's exactly right.

DT: Yes.

FC: The people that formed the Academic Health Center came from a variety of areas, as I think you know, from the Legislature, from an internal faculty committee, from an external committee called by the president, from a statewide group of business people. They got together and said, "Yes, you should do this for the reasons that you mentioned." But the vice presidency never developed to make that happen for years and years and years.

The first vice president was a great man. He did a lot of good stuff. He was well connected with the Legislature. He got a lot of buildings built. He was well liked. But it never solved the silos issues. It just wasn't part of the agenda and the clinical chiefs didn't want it. They all had their own practice plans. They were all making lots of money. Even at that time, for instance, in some of those practice plans, the chair got the money, not the faculty. It would go ahead into the chair's foundation. Several of the departments operated like that. Surgery didn't. In Surgery, you pretty much got what you earned and, then, you paid your share of the expenses. It was a very fair system. I didn't have any problem with it. I didn't know at the time that there were several accounting systems. That kind of came out during the ALG thing. But if you worked and made money, you got your money back.

[chuckles]

FC: You were able to use it as personal income and you paid your share of the expenses. I never thought that was a bad thing. I never understood this… You know there were

just these bunch of deals cut in the 1970s. The Regents knew the clinicians needed to practice, and they said, "You can practice. You can each have your practice plan." It went through various stages of third party oversight and so on until we finally got to form UMP. But it was a funny system in the sense that it was controlled by the department. The oversight was there by a third party attorney who attested that you got what you deserved to the Board of Regents. But, there was kind of the deal there where the clinical chairs will support the Medical School if they're allowed to manage their own private practice. That's when that model developed across the country so you had clinical revenue, NIH revenue. It turns out because of its size, the Medical School had the most state money of any school in the University. But when you looked at it as a percentage of its budget, it's very, very low and has gone down. Some of that money was taken to expand the College of Liberal Arts and all of that kind of stuff that's historical. It was the beginning of the model where the Medical School became dependent on research revenue—which, of course, doesn't pay all the expenses; it pays, best case, seventy-five percent—and the clinical revenue…

Today, half the Medical School's budget is clinical revenue in a market where the margin per work unit is decreasing and is going to go away very shortly. In a market where sole practitioners are a thing of the past, where the salaries that people want to get paid are driving those practices into no margin, you will see beginning over the next several years, the laying off of specialists and sub-specialist physicians because you can't support their salaries. It's just a *huge* fixed cost, and you can't generate it. The answer used to be volume, and that's what's going away.

That all started way back when when there was nobody looking five, ten, fifteen years downstream, there was no connection with all of the resources of public health, which is full of people who think about this stuff day and night and do the research and do the predictions and who know how to use all that stuff. There were no connections made about, okay, where is this going and how is it happening. The unexpected in their minds, of course, became what happened. The Medical School got in real trouble, was in the red, took a dive in the ratings, and became *vulnerable*, I think is the word.

It was a very interesting time once I began to see what was going on and understand the mentality of the administration of the Hospital. Then, there was a series of vice presidents, one year, two years, three years. What was Brody? Two and a half years? That just kills you in my opinion. With that turn over of leadership, you go nowhere. It causes anarchy, and that's exactly what happened. That's not an original thought. I think there was another famous guy that came up with that thought.

DT: [laughter]

FC: It began to unravel.

Then, the president [Kenneth H. Keller] that took over got himself in real trouble. He tried to do strategic planning. Whatever the reasons were… I don't understand all of that. I really liked him. I thought Keller was a great president. I really thought he had

vision. He knew what needed to happen. He was willing to take the heat to do it. Then, somehow, he got, I don't know what to call it, *media-ed*-to-death over some stuff that never made a hell of a lot of sense to me. So he had a big desk. So he redid the kitchen [in Eastcliff] so he could do the philanthropic entertainment that presidents need to do. So he had a fund that was an emergency fund that he could invest. Presidents need those funds to change the direction of a university like this. I don't know what that politic was about. We lived through that. Then, we had leadership in Morrill Hall that tried to do a strategic plan, but it never went anywhere. It just failed. Then, the big blowup over tenure and all that kind of stuff. I think this theme of lack of a real strategic direction and plan that was both bottom up and top down, not paying attention to what was going in the marketplace, not thinking downstream of what the workforce demands were going to be and what we ought to be doing about them, not understanding that the future was going to be interprofessional in its nature and that teams were the future, and not seeing that the payment systems that we were on were simply not sustainable, just not sustainable. That was evident in the 1990s and nobody did anything.

DT: You mentioned the formation of University of Minnesota Physicians. Before that, it was the University of Minnesota Clinical Associates.

FC: Yes.

DT: I wonder if you could talk about that development.

FC: Well, there was some really good clinical leadership that evolved. Roby [C.] Thompson is the star. Roby saw a lot of this. He saw that these fifteen, twenty different practice plans were not going to cut it, because the contracting people in the community, the insurance business or sometimes the system business depending on the configuration, didn't want to do twenty different contracts. They wanted one contract. So the effort to unite the contract business was UMCA.

Then, it became apparent that the physician and the Hospital contracts were the same kind of issue. So they founded the University Health System, which led by Greg Hart. Greg is an *incredibly* capable, thoughtful leader, but you had this business that the Hospital was still under the Board of Regents. It struggled to do the decision-making it needed to do. The administration of the Hospital was focused on its small market share and getting what they could for reimbursement as a University. You had all these problems. If you're running a clinic and you need five FTEs [full-time equivalent] for an afternoon full of patients, you'd like to do it with five doctors, not fifty.

DT: Yes.

FC: Well, we had some of those with ten heads per FTE. That's a very inefficient clinic system. The faculty were, basically, rewarded for academic productivity, for grants, papers, meetings, awards and not for clinical practice and, basically, not for educating. That's where the premium was and that's how you got tenure. Tenure didn't mean a lot to the clinicians, so to speak, but they were still held to those standards for promotion in

what became a non-tenured system, a clinical track system. If you look at where the grant money is in the Medical School, it's in the clinical departments, the big grants—most of them. How do you do that? Some of them hired basic scientists. They, sometimes, integrated with the basic science departments; sometimes, they didn't. So it became just a non-viable system and, finally, crumbled. The Hospital began losing money. The market share went down. The leadership, Roby and Greg said, "Oh, boy, we've got to get to a single practice plan here. We're going to be dead in the water." That's where the movement that ended up with UMP came from.

That was probably the first big experience I had in bringing together very diverse goals, philosophies, mental models, objectives of the eighteen different clinical departments to try to get consensus around what a single organization would look like. As I said, then I left that to become dean and Steve Haines picked it up, but it ended up in a good place. I think it functions quite well. They've been able to substantively grow their business, but they're, basically, a specialist and sub-specialist organization trying to stay in that model as a referral base and an accountable care system, but working on a relative value unit margin that's contracting and the payments systems are moving into a very different global fee type of payments, of capitated type of payments. They're leveraged and seventy, seventy-five percent of their business is coming from outside of Fairview. As the other health systems see their margins narrow, they're going to do everything they can to keep those patients in their system. Most of them have physicians who are employees, so they have a better opportunity to do that. As an employee, as an employed physician, your boss can have a lot to do with where you refer patients. So I don't think people are seeing that.

Again, I don't see a long-range strategic plan. I think there was a practical operational strategic plan that came top down, bottom up after the turmoil of 1990s that actually can claim a great deal of success in moving the Academic Health Center to be an academic health center, to begin to break down silos, to get people to work together, to think about interprofessional education in a professional practice as well as interprofessional research. Some people would say, "Well, the Medical School suffered for that." My response would be, "I don't know the answer to that, because if you want to follow the traditional pathway of making the Medical School a top ten, you've got to make it into a silo and that's not going to fly." It's just not going to fly.

It gets to one of the issues of what do you do when you recruit leadership? I, eventually, got to the point where I said, "Recruiting deans based on their academic curriculum vitae and bibliography is simply the wrong way to go. They need that to have credibility in the academic environment, but if they can't manage, and they can't administer… You need to have concrete evidence of what they have been able to accomplish, particularly with diverse groups of people, getting them to agree on a direction and, then, perform. If they can't do that, they shouldn't be in those positions. I feel the same way about department heads. This business of all the time, "what's in it for me, what's in it for me, what's in it for me" should be "what's in it for us." We float the whole boat and everybody wins. That's a concept that still isn't here—and it's still not here in the health system.

Our health system is a bunch of competing organizations for their bottom lines. They're beginning to change—they haven't been changing—as the focus has shifted to performance and outcomes particularly around the Triple Aim.

That's kind of a hop, skip, and jump, but it's the thread of those themes that evolved that have defined who we are today.

DT: Going back to the issue of interprofessionalism… I see the establishment of the Biomedical Ethics Center in 1985 as one of the early examples of interprofessionalism. I don't know if you recall the establishment of that center and if you have any insights into that.

FC: I clearly remember that and, yes, I was involved in it. It fundamentally grew out of the issues that were derived from patient care.

We were fortunate to have Shelley Chou here as chair of Neurosurgery and, then, dean. Shelley was the one that led the effort around brain death and established it as a medical and legal foundation for death and the circumstances and criteria under which it could occur. To do that, you needed third party people who dealt with, I'll just say, ethical mental models and approaches so that that was appropriately managed.

Then, you had the development, at that time—this was the late 1980s, I think; I can't remember if it was before or after the ethics group—of several physicians who were charged with homicide because of their use of pain relief in terminal patients. You had three or four patients who were terminal. They had reached the stage of futility for months. They were just going to die. Narcotics were used to relieve pain and give great comfort. One of their side effects is they'll drop your breathing rate and can stop you from breathing. So the medical examiner labeled these, I can't remember if it was two or three, as homicides.

That kind of rolled back up to me. I put together a national group—I think it was for the Hennepin County attorney, at that time, that we did this—of experts like Ake [N.] Grenvik from Pittsburgh, who was one of the grandfathers of critical care and a card carrying ethicist himself, and several people of that ilk who wrote a report to I believe it was the county attorney, at this time. It said, "Look, you've kind of got this dual effect. You've got to relieve people's pain. In some cases, they may quit breathing earlier than they would have if you didn't. That's a side effect of the drug. It's not a homicide in the sense of intent." So there was a compromise reached where if it was well documented in the chart why the drug was being used, what the dosage was, et cetera, that that would go away. But that was, again, another round of ethics.

It was, then, the whole heart transplant business. Many people believe the heart is the seat of the soul and you're taking one soul from somebody and putting it into another, so there's all of that controversy that was ethical in origin.

So the circumstances of the clinical environment were driving these changes. That's a major theme of what happens in health science communities. They're always pushing the envelope as progress is made in the prevention and care and treatment of disease. You know it's done for good reasons.

Also, then, out of that came the institutional review board movement of which there was very little up until the mid 1980s. That's also an ethics issue.

So you put that all together and, well, we need an ethics group, but they need to be independent. That's why, for a long time, they were funded only on state money so that there was no way to influence them based on finances. It worked. It was very helpful and clinical ethics evolved. Art [Arthur L.] Caplan was the original one. He was fantastic.

There was also a Medical School accreditation report at this time. It was very clear that we needed an ethics committee, that we needed somebody to run information systems, and that we needed somebody to manage human resources, and that we needed somebody to manage facilities, because the University was not doing it. That's where those positions came and when I became dean and v.p., I elevated those positions to the Academic Health Center level, which is where they still are. We didn't want to duplicate what was going on for these services by the University. We had to figure out the interface. It worked.

The same was true with communications. Communications that existed in the 1980s was, basically, circle the wagons and fight the bastards. You can't do business that way as a public institution. You really have to have relationships with the media. You have to talk to them about what's going on, the very good, the good, the bad, and the ugly and be very clear and open and help them report accurately and factually. Part of the problem is that many of the upper University governance administration have what I call a policy by newspaper. If something bad got in the paper, well, something needed to happen to fix it right away, because it's making us look bad, instead of saying something like, "We understand. Now that we've seen this pointed out, we're going with it, and we'll come up with a good solution, and we'll keep you in the loop." That's much of the ALG story in a nutshell: this defensiveness, lack of openness, lack of transparency.

I remember once when I was dean I said, "Give me a P&L or give me a balance sheet of some kind so I know where we are," basically, give me a budget report. I was told, "We can't do that. We have to do it by pencil."

DT: [chuckles]

FC: What? How can you run a billion dollar business…? This goes back to this very tight vertical decision-making structure where everybody controlled finances, and nobody knew what was going on, and nobody wanted to tell people what was going on. That just doesn't sit well with me. This is a public institution. People have to know. You have to tell them, "Here's what's going on. Here's what we think. What do you think? Here's

where we are strategically. We wanted to go there. Do we change? Do we not go? Here's our finances."

So when I got to be a v.p., I put them all out on a website and redid the financial systems. I just blew that wide open and said, "Here it is, guys. Deal with it. What do you want to do here?" They said, "You know tuition isn't well distributed." I said, "No, it's not. It's not going where the people are doing the work." So Mark [S.] Paller took it on and we changed the formula for how you distribute tuition. The same with ICR [Indirect Cost Recovery]. It's that kind of stuff that just wasn't there.

What am I saying to you? In reality I'm saying you need professional managers to run billion dollar businesses and the substructures that are underneath them. I'm not suggesting you bring an MBA [Master of Business Administration] in to run a department of surgery. That's not what I'm saying. But you certainly can recruit a good surgeon who has good academic credentials, knows how to operate, who also has management skills. That's what has to happen. If they don't have them, it should be a condition of employment. The same with deans and the same with vice presidents and, in my view, the same with presidents. We still hire presidents the way we hire department heads. I just don't think universities can function that way anymore. It's a business. It has to be run like a business—actually, three businesses on one platform. In one platform, you do education, you do research, and you do clinical practice. It makes people very confused about what goes on in health sciences—[chuckles]—and then you get all, as I said, of the real good, the good, the bad, and the ugly out there in the media.

You lived through all of this pharmaceutical device conflict of interest stuff. Basically, that ended up in a good place. We put in place a good compliance system and a good research system and, finally, got some legislation that exposed what drug companies are paying people. It's no longer a secret; it's transparent. But you know something? All the people that were accused in the paper, there was never any real evidence against them. Nobody was convicted of anything. Nobody was punished for anything. Nobody was even really reprimanded. So all of this hoopla…in my view, basically, because you play everything close to your vest and you don't talk to people and let them know what is going on. If you don't have good relationships with the media and something goes wrong, you're going to get slammed. You're not going to get a fair story. I think this latest business with administrative costs is just another example of that.

I got a little off the track on that.

DT: [laughter]

FC: You kind of get the idea.

DT: Yes.

FC It's out of this clinical environment that the basic science questions come in health sciences, of which innovation comes around new drugs, around new devices, about new

methods of treatment that are neither drugs nor devices. It *moved* that therapeutics ahead. Unfortunately, it didn't consider the people, the communities, the payment systems, and all those other things. We used to call them eddy currents, which are now the major drivers of change. They were created because of the progress that happened in the health sciences.

DT: One of the reasons I brought up the Center for Bioethics… What I've seen in the Archives is that the medical students had had something of a role in getting it set up, because of the ethical challenges.

FC: Oh, I forgot about that.

DT: [chuckles] That's fine.

It was the questions around brain death and euthanasia, abortion. The medical students had wanted to be better prepared. So the students had raised some questions.

FC: All true. I just didn't keep going down the list.

DT: [laughter]

FC: I thought I had made the theme and made the point, but those are exactly true.

Some of those actually ended up in the Legislature in 1996. I think I was a fresh dean when Brody called me over to the Legislature. It was in a conference committee, so the final stage of the law. The chair of the conference committee said, "Here's $30 million. If you'll stop teaching abortion, we'll give it to you." Brody said [to me], "*You* need to answer this."

[chuckles]

FC: I said, "Look, abortion is legal in the State of Minnesota. This is a public university. We have to teach it. It's on the accrediting standards. It's in the exams. We have an opt-out mechanism. If you don't want to give me the $30 million, that's your business, but I won't stop teaching abortion." There was dead silence in the room.

Yes, this is exactly what was going on, and it was the beginning of the era of in vitro fertilization. It was the beginning of the era of what I'll call the development of cells. The genome business was ramping up. What you could do manipulating cells outside the human body and putting them back in was becoming a reality with the research that the John Wagners [John E. Wagner] of the world were doing. All of this is fantastic stuff, all of that stuff. Then, of course, the Right to Life people were taking us to task in the Legislature to try and stop stem cell research—I'm moving ahead here a little—and all of that stuff, all the ethics around when life begins and what do we do with embryonic stem cells and can we really make them work. Well, it turns out, you can make them work. You can get them to differentiate. Some claimed we were we in violation of Minnesota

law to tried to get the attorney general to, essentially, sue us? None of that came to fruition, but, again, all the issues surrounding it and providing a framework… Again, what is the approach to these? The approach I took is transparency, open discussion. This is a public institution. It is the place where these things should be debated and just have this progressive series of debates about all these topics, pro and con, in a kind of environment where people can say what they wanted to say and people would listen and not storm out of the room and get angry…have a dialog.

The other thing I think I learned at that time is, if you're in the middle of that kind of stuff, one, you've got to get connected with your people in a very real way, and, two, you have to spend a lot of time in Saint Paul talking to the legislators. I spent a lot of time talking to the most liberals, the most conservatives, the middle roaders of both parties, reaching understanding, reaching compromises, understanding their point of view, getting them to understand ours. It kind of smoothed itself out. If the leadership isn't willing to do that, it won't go anywhere. It just gets polarized. I worry about that in the leadership of the University. I think people need to understand that the vice president for health sciences is a very public position. It is always in the middle of that stuff whether you want to be or not. There isn't much that happens in health that I wasn't in the middle of. Some people liked that; some people didn't.

DT: This was a few years before you were dean and, then, senior vice president, but, again, I see as another example of this interprofessional practice and research, the establishment of the Cancer Center that John [H.] Kersey had a big role in.

FC: Yes.

DT: Do you have any reflections on that, particularly in terms of it being an exemplar of what the Academic Health Center stood and stands for?

FC: Yes, I think this is one of John Kersey's great legacies along with the other cures that he developed. He was just a very unusual man. He had a lot of vision, a lot of foresight. He could get people in a room and get them moving in the same direction. He worked with Nils Hasselmo, the president, and established this concept of a cancer center. We got some state money. I think the dean put more money in. They had a community swell, and they built what is now the Cancer Center.

That's kind of when I got involved. There were some cost overruns and that's kind of how I got involved in it. But the more I got into it, John and I would talk about this. I said, "John, I'm a thousand percent supportive of this, but this is, basically, a research institute. He said, "Yes, it is." I said, "Why isn't there a clinical component?" There was no chance in hell of getting that through the clinical chairs. There was no way *they* were going to share any of their resources to help the Cancer Center and move the care of cancer patients to the Cancer Center by cancer physicians. There's a perfect opportunity for interdisciplinary clinical team development and, they didn't want to do that. That's a theme that developed. That attitude blocked more things, in fact it's in most of this list I've been talking about, until we could get over it.

So the Cancer Center happened. Then, the Masons took a big interest in it for a variety of reasons. They had a lot of people with cancer. Phil [Philip B.] McGlave was very close to the Masons. They funded his lab for many, many years. Phil and John, basically, worked with the Masons to get interest in cancer. I got involved in that and that's where the big Mason's donation came from for the Masonic Cancer Center, the $65 million gift of the Masons to fund cancer research. That was actually fun. I almost became a Mason then, which I may still do. I just haven't got back to it. I like those…they're really a good group of people and they do a lot of good work. So that was that.

Then, it was, okay, John, where are we going? Well, we wanted to become an NIH certified institute, so he led that very successfully, and we still have it. Then, he stepped out and Doug Yee came in, who I thought was the right leader, after a national search. They continue to do very well.

Then, John and I began to tackle the clinical piece. We never got very far before he retired. There just was a lot of resistance to that kind of stuff, as opposed to developing something that was a real clinical cancer center tied together for research where the whole boat benefited everybody. Maybe it will come back. I don't know. It's just another missed opportunity.

I think all of these missed opportunities had a lot to do with the sagging ranking. A lot of that sagging got undone, except for the Medical School. We could never get above, what, twenty-two, twenty-three, which was, basically, a resource problem. You've got this problem where the state money comes into the University and the University decides where it goes. It was a question: are you going to make the investment the Medical School needs to get back where it needs to be? The answer was always, "No."

Well, then, the idea for the Biomedical Discovery District came. "Fitz" [Richard H. Pfutzenreuter] had a lot to do with that. He really had a lot to do with that. We made it happen. I said, "You know we're going to need another $200 million to fill this." Well, that hasn't happened. That's kind of the story: build the building but not the program, and, oh, I can't give all that money over there to health sciences. Gee, health sciences takes all the money. Yes, well, they're sixty percent of your revenue, sixty percent of your patent profiles, and so on and so forth. It's where the action is. It's where the reputation of the University comes from, for the most part. You have to decide. Do you want it or not? Now, the mantra is, "Support the Medical School." But I don't see the $200 million on the table, and I don't see it coming, and that's what it's going to take. You've got $50 million to $60 million alone to recruit a new chair of Medicine. You've still got to play the research game here to get where you want to go.

The other opportunity that came up for the University and health sciences is this whole business of the National Center for Interprofessional Practice and Education. It is *the* opportunity to take the national lead in education and clinical practice. It's that kind of thing. That's another topic.

DT: I wonder if we could actually now talk about the ALG situation in some detail seeing as we've alluded to it several times.

[chuckles]

FC: Well, that's a big piece of the history. To do that, I'm going to need another cup of coffee.

DT: Okay. [laughter] I understand.

[break in the interview]

FC: Okay, the ALG. I'll tell you what I know. I only know pieces of it. So you'll just have to put up with that.

My introduction to ALG actually came in the ICU. About the time I got here was when liver transplants were starting and pancreas transplants, and ALG was commonly used. It was something I didn't know anything about, so I learned about it. It was and actually is probably the best anti-rejection drug that was ever developed.

It came out of the mind of John Najarian, and it was put together with another guy. I can't remember his name [Richard Condie]. He knew how to make serum. They had a building where they were producing it. They met all of the specs for producing those kinds of biologics, and they tested it. I believe they had an FDA [Federal Drug Administration] approval to test, but not a final drug approval. So they never did an NDA [New Drug Application]. They used it, and they published a *lot* of papers on it, nationally and internationally, to show its effectiveness and its efficacy statistically, but they never filled out the case reports. They stood and stood. It seemed like nobody wanted to get the department to fill out the case reports. It was always somebody else's problem. The president gave it to the v.p. The v.p. gave it to the dean. The dean gave it to the department head. The department head gave it to this other guy who was running the case reports, and they never got filled out. I think there was a feeling that since it had been published in peer-reviewed journals and everybody was using it worldwide… There was a part of Medicare where you could get cost recovery under these circumstances, so they got cost recovery and had enough money to build the new building that was approved by the Board of Regents. It went up through the hierarchy of approvals, and actually it's still up in Saint Paul.

Then, as the story goes, there was a drug company that was producing a new drug, Upjohn. The story as I heard it was that it went to the FDA, "Hey, you want us to get an NDA. Why aren't you requiring them?" That's when the request process began and there really wasn't much response. Finally, the federal marshals came in and took the equipment and, basically, put the University on probation, as did NIH. They did their investigation and said, "This university has an environment of non-compliance across the university." It ended up in a federal lawsuit. Of course, the University countersued.

There was a big hullabaloo about it. John Najarian stepped down. He, eventually, went on trial and was acquitted. It, finally, all got settled.

Part of the process was a corrective action plan with the Department of Justice in the University to redo from the bottom up, the whole research process, which is something President Yudof had me lead. I worked on it with Dave. What's his last name? He's a cell biologist.

DT: [David W.] Hamilton?

FC: Hamilton, who was the vice president for research…and a few other people. We put together this team, and we developed a corrective action plan. It was approved by the Justice Department and the NIH. We implemented it, and that's what we still have today.

A piece of that was the compliance system. I put that together with another interdisciplinary team. That pretty much exists as it exists today with some redo of the policies based on the attention of the last several years to physician payments by drug companies and device companies. We now have this University-wide conflict of interest process in the policy. It actually works very well. It's run very competently, and I think is not very intrusive. There's an educational process and a recertification process. That all grew out of that, so the University became a very different place and, then, we were finally taken off designation.

In the process, we sold the Hospital. I think it was for about $85 million. About $50 million or $55 million of that paid the legal fees and the penalties to the government. The Board of Regents used the other $25 million or $30 million to pay off, to defease the debt on the steam plant. The Medical School ended up with zip on the sale of the Hospital.

That and the abrupt firing of the chair, the lack of transparency about what was going on, being pummeled by the newspapers because of the lack of transparency, and because of some of the vendetta they were on with Joe Rigert [*Saint Paul Pioneer Press* reporter] and his group, it was just a horrible time. The morale was in the cellar. The provost came along and said, "Tenure is the root of all evil, and we're going get rid of it; we're going to get rid of schools, and we're going to Champy and reengineer." We found out, at that time, from a community survey all the things that they had to retrain in our graduates, which is still true today, never got fixed. That caused more turmoil. The move to unionization, the sale of the Hospital…and then the provost left. That's when I was asked to take over.

That's all the ALG business.

This is my personal take… I think had the people in administration said, "Look, either fill these case reports out or we're going to shut you down," it could have all been avoided. It didn't need to happen. It happened because of a lack of oversight and administration not doing what they were supposed to do, in my opinion. If you have a study that big going on on an experimental undertaking, and people are telling you,

"You're not getting case reports so you can't submit an NDA," it's the administration's job to get that done—but it didn't happen.

DT: The University, then, sued Doctor Najarian or tried to press charges against him or took him to trial. Why do you think the University took that action?

FC: The University didn't take Najarian to trial. The US Attorney General did.

DT: I thought the University lawyers did something against him, that they were trying…

FC: Oh, that wasn't why he went to federal court. The Department of Justice took him to federal court under [U.S. District Judge] Justice [Richard] Kyle for a variety of charges they made against him…

DT: Right, I know that part of it.

FC: …for travel and that kind of stuff.

What the University did is they had the right to depose him as department head, but he grieved them. So in the grievance process, the question was, what's the deal here? There were his clinical appointment, his academic appointment, and his Regents professor status. At that time, the FDA, Food and Drug Administration, had disbarred him for life from doing clinical research. The NIH had done a similar kind of thing. So the question was what should the University do? There was a lot of pressure to do it. I was dean at the time. So they took away his academic title. They had this faculty committee that said he was guilty of academic misconduct led by the dean of the Dental School as part of the FDA evidence. There was talk of taking away his Regents professorship, but that never really happened. It's more of an honorary thing. I think the money went away, but I'm not sure about that.

Then, I got a call from Bill Brody that says, "What do you want to do about his clinical appointment?" I said, "Bill, my position on that is, it's one thing that he's no longer department head, he's no longer leading those programs, and he can't do anymore research, but he's made major contributions to clinical transplantation. He's an outstanding surgeon. He's able to manage patients that nobody else wants to even try to manage. I will retain his clinical appointment and his office." He said, "Okay," and that's the deal that was cut. That was that piece.

DT: Okay.

FC: It was a settlement of a grievance. John still has his office.

You know the Wall of Honor that's over there?

DT: Yes.

FC: ALG is on it. This came out of a faculty effort as to who should be up there. They recommended John Najarian be up there with ALG. It was fought by the General Counsel's office. It, finally, came back to me and I said, "You guys are nuts. This is our man. We can't say he didn't work here. He's us. We're him. He did this. It's saved thousands and thousands of lives. How can you *not* give him the credit for it as an innovative invention? You have to. You'll be remiss if you don't." I prevailed. That's how it stayed up there. I think President Bruininks had to finally approve that. He agreed with me. He said, "Yes." If you look down the rest of that list, you'll find some sordid histories, too.

[chuckles]

FC: Them's us and we's them.

DT: [laughter]

I was wondering what was the reaction of the faculty in the Surgery Department in the Med School to the situation with ALG?

FC: The department knew it was a great drug, and they all just felt this was a lot of bureaucracy.

The best way I can explain what happened is, it came time that the Board of Regents wanted to name a facility after Nils Hasselmo. It used to be the Biomedical Sciences Building. They wanted to name it Hasselmo Hall. They wanted people from the health sciences there for the dedication. Well, I was the v.p. and I said, "Geez, I'm going to be out of town." The dean was out of town. Everybody said, "I'm not going to do this." Finally, I think Leo [T.] Furcht went for a little while and left. It tells you the attitude.

Again, it was some of what was done but it was mostly *how* it was done. When the president walked in, he'd never been in the Academic…[Health Center] There's never been a president in the Academic Health Center since I was here, at least since 1981, so at least twelve years. He walks in, "Your boss is fired." No explanation. "Effective today. Goodbye." That was the attitude of how you work with your community. It was just polarized and it took years to go away. I don't know yet if the trust with Morrill Hall has ever been restored. Bob [Bruininks] did a lot to improve it. It was a big problem.

DT: Another issue that had legal issues around the same time, not to the same degree as the ALG situation, was Doctor [Robert] Vince's role in the development of Ziagen.

FC: Yes.

DT: That had some legal issues around the patent and attribution. I wonder if you could speak to that.

FC: Well, yes, I was in the middle of that one. It was a question of who developed the intellectual property and how should it be partitioned? That actually got worked out.

There were two other issues. One is I think it was Glaxo [Wellcome, at the time; later GlaxoSmithKline], they began to make a claim on the patent. Then, there was a problem with their distribution of royalties. It was all tied up in this bundle. There wasn't a lawsuit, but there was a threatened lawsuit. It never went to trial. We, finally, negotiated a solution. The royalty distribution from Glaxo was solved by an audit, and they ended up owing us a lot more money. I make no claims as to what was intentional here, what was not. There was not a good relationship between Doctor Vince and his graduate student. There was the threat of a patent lawsuit on that, but it got resolved, is my understanding. I don't think a suit was ever filed. I think it just got resolved. So that was that. It was a big effort. It was a big deal because there was lots of money involved, but it got resolved outside of court.

DT: Then, with some of those royalties, the Center for Drug Design was established in 2002?

FC: Yes. The University's royalty policy, once the royalty money got in it, was a third goes to the inventor, a third goes to the school, and a third goes to the vice president for research. Inside the school, one half of one third goes to the dean and the other two… [pause]

[chuckles]

FC: It gets confusing. One sixth ends up with the dean and the rest of that one-third goes to the department. It's a funny way to talk.

So Bob took his money and created an endowment for the Center for Drug Design. He also created endowments for all the members of the Medicinal Chemistry Department. He wanted the Drug Design Institute outside of the College of Pharmacy, for his reasons. It's done very well. It's been very productive with a lot more new intellectual property. He became very well off. He's done a bunch of endowments. He's done a lot of good with his money. The vice president for research put a lot of it into scholarships, fellowships, those kinds of things. So the money was very well used. I don't know what happened to the funds in the school. I think it mostly ended up in the department in support and research.

There's an interesting sidelight to that. It didn't happen to Bob. Bob's funding of the research in his center is stellar, but in the department when the faculty had their own research endowments, the grant productivity went down until a new chair came back and reestablished the need to get competitive grants, with a few exceptions. Like Phil [Philip S.] Portoghese who has always been a star. He's what? Eighty years old or something and still got more grants than I ever had. He's just really a good guy. That's what I know about that.

DT: So the new dean being Marilyn Speedie?

FC: The new department head, Gunda Georg.

DT: Oh, okay.

FC: I probably misspoke.

DT: No, that's right. I was thinking dean.

FC: Yes, Marilyn was dean.

DT: Yes, I was misspeaking.

When I interviewed Yusuf Abul-Hajj, who was then chair of the department I guess before Gunda, he had spoken about some of the tensions around the creation of the Center and what direction he wanted it to take versus what direction Doctor Vince wanted it to take and that you had served as something of a mediator.

FC: Yes, that's a true story. It's an interesting issue because here sits Bob with his money who says, "I want to establish the Center for Drug Design." He knew exactly what he wanted. Here's Medicinal Chemistry. Yusuf was representing the department as department head. They said, "We really think that Center for Drug Design should be inside the school in the department and here's what it should be." And it wasn't the same as what Bob wanted. Bob really wanted modern tools for the design of new drugs that could then be tested and he wanted to generate a group of people that that's what they did. He decided the only way he could do that was to have the Center outside the college and in the Academic Health Center. That way, he could bring in different kinds of people and it would be his Center. That's what I brokered, because it made sense to me. It isn't like we were using somebody else's money. He paid for his space. He paid for his people. Why not? It turns out it's been very productive. The tension mounted when Gunda came, because we invested $30 million or $40 million in her development of new drugs, some of which was designed, but most of which was just drug development and a variety of tools when we rebuilt that old health department building. So there was a big move to try and put them together, but it just was not compatible. It would not have worked. Some of it, I think, was vision. Some of it was personality. Some of it was Bob really knowing what he wanted to accomplish and having the certainty that he could accomplish it, which he did—or has. And I had faith in that, so I permitted it.

DT: One other thing about the Ziagen… I saw in a newspaper story that there were some campus protests around the prohibitive costs of drugs in developing countries for HIV/AIDS [Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus], Ziagen being one of them.

FC: Yes.

DT: Could you speak to those protests?

FC: Well, there was a lot of feeling, and some of it was in the faculty governance, that the drug should be given to the Third World countries where it's needed. The problem the University had was we can't do that. Glaxo owns this. If it's going to happen, *they* have to do it. We can't force them to do it. We're also bound by the federal Bayh-Dole Act to get the best returns we can. So we talked about that and argued that out. Those were the arguments that were made. Two things happened. One, Ziagen was declared not to be a first-line drug for AIDS by the World Health Organization or CDC [Center for Disease Control], one of the two or both. Then, President [George W.] Bush ended up with a major funding for AIDS drugs for Africa and that issue kind of disappeared. It was an interesting issue. I had a lot of empathy for their position, but there was nothing to do. I was the senior administrator on that. I said, "There's nothing I can do here."

DT: It depends on the drug companies.

Going back to Brody's short tenure as provost… You mentioned the Champy reengineer, his wanting to institute that. What was his rationale then for abolishing tenure and why did he create a provision of provost instead of senior vice president?

FC: He didn't create the position. Nils Hasselmo created it on the advice of a group of senior business leaders in the community, the main one of which was Win [Winston R.] Wallin, who is now deceased. He was a major friend of the University, a major personal mentor, former CEO of Medtronic, and he worked to come up with this three-provost system: one for Ag, one for health sciences, and one for everything else. That's how the three-provost system came about.

What was the first part of your question?

DT: Why did Brody want to abolish tenure?

FC: In his mind, tenure was an impediment to change, as were the silos of professional schools and their lack of interaction with each other. I'm simplifying this a little.

At that time, Champy had come out with his book on reengineering, which had had a great deal of success in the business world. It didn't last, but it started out with a great fury. The idea was you take a blank sheet of paper. You figure out where you want to be and, then, you create a design to get there. Groups come together in affinities around issues that need to get done and dealt with. You really don't need deans. You just start from scratch. He married those two concepts. He started out with something called the QRTC [Quality Re-engineering and Technology Committee], which was a group of people. Leo Furcht actually led a lot of it. There are probably twenty tapes of this over in the Academic Health Center of these QRTC meetings of trying to figure out how do you actually do this. How do you take a blank sheet of paper and make it happen?

That's where the survey of the community came from that I referred to before, about what are we producing that isn't fitting out there. They don't know how to work in teams. They don't understand systems. They don't understand costs, so on and so forth, the same litany that's there today across the country that we hear from the national center. Nothing ever happened, because it all died.

It was interesting to watch him work. He was a very smart man. He's the one who figured out we really ought to sell the Hospital because there's not another alternative that can work. He just felt strongly that this was the way it had to go, and that was his first public presentation. Nils let him get money from the Legislature to do it under the aegis of several members of the Board of Regents. It instituted a war.

DT: [chuckles]

FC: That's the only way I can say it.

Then, one day, he just left. He called up and said, "I'm leaving and, Frank, you're the only one that can deal with this." I said, Thanks, Bill.

[laughter]

DT: Here, have this hot potato.

FC: So that's where it was. How shall I say this? I was never able to, so to speak, get inside his head. I think he knew there needed to be radical change. He could see what was coming down the road in healthcare very clearly. Everything that's happening today, he saw and predicted. He said, "If we don't change now, we will not be ready to respond to that, and we may fail." He could turn out to be a real prophet. I think that's what drove him. There were several members of the Board of Regents who felt the same way, and they said, "Let's tack a whack at this." Then, it just blew up.

Tom [E. Thomas] Sullivan, who became provost, who was dean of the Law School, rewrote the tenure code. That's where post tenure review came from, such as it is. It was approved by the Board of Regents to stop the war, basically.

The vote for unionization in the non-health sciences was *very* close. It was a matter of a few votes. Here, the clinical faculty were informed of what was going on, and the vote to unionize was resoundly defeated. Then, I was sued for a violation of the labor law, which got dropped.

DT: What were the grounds for that?

FC: That I had incited the clinical faculty unfairly to vote against the union.

[chuckles]

FC: My personal feeling is I wasn't for or against the union, and I said, "Because I don't see the difference between that and tenure. They're the same. They're just called different names. If you want to form a union, it's okay with me. I don't mind collective bargaining. I know how to work with that and get stuff done. In many ways, it might be easier." So I didn't have an opinion pro or con. And that's what prevailed. I was very public about that. The question to me is, I just want to know who I need to work with to get something done.

DT: I wonder if we have time to talk about the sale of the Hospital, or I can ask you a shorter question.

FC: That's a long question, the Hospital one.

DT: That's what I figured.

FC: Ask me a shorter one.

DT: I'll ask you a shorter one.

I'm going to jump ahead in time. Sticking to the interprofessional theme that we've hit upon a few times… The Institute for Health Informatics is going to be celebrating fifty years in 2015. I have a vested interest in this question.

[chuckles]

DT: There's a longer history of Health Informatics at the University, but the Institute itself was established in 2005 in the Academic Health Center.

FC: I did that.

DT: You did that, so I wonder if you could talk about why the Institute was established and that process.

FC: Number one, the Informatics Program that was here was of great stature at one time but had *really* fallen off and we lost the Library of Congress [correctly, the National Library of Medicine] grant and the divorce with Mayo [Clinic] occurred over this. They gave up the whole issue of health records and the development of electronic health records. They didn't want to deal with it. That was kind of one group of happenings.

The other group of happenings was the development of large research databases and the ability to manage whether this was financial data in public health, big epidemiologic studies. We were involved in six or eight major multi-university agreements, worldwide clinical studies, a lot of the bursting of energy around genomics and the genome. I said, "You know, we're not prepared for this. We don't have the information infrastructure to deal with this." So I took it to Yudof, and I said, "What happens here? We have all this information but we have no knowledge about how to really use it. It's all mom and pop

stuff. It's all based in databases that can't talk to each other. There's no commonality of fields. There's nothing." So we talked about it and talked about it. Finally, he said, "We need a university-wide genomics program."

So I helped develop that with the faculty. It's got to be university-wide, but the guy that was supposed to work on the University side didn't do anything and it, basically, like everything else, became the health sciences that developed the Genomics Program that everybody used. Then, Engineering came on board, and it began to really work. That led to even greater demands for an information infrastructure. Then, out of the CTSI [Clinical and Translational Science Institute] world—this was the third piece of development—came the initiation of the development of the informatician going way beyond biostatistics, particularly in health informatics, a piece of which was the electronic health record. But how do you deal with all of this data from all of these different institutions and get it to come together in a unified database that you can prospectively fill and do something with so that we can get out of this mess of just dealing with clinical data? That led to the development of the idea that we really need informatics here.

About that time, I was recruiting a new dean in Nursing. Connie had applied and there were a whole bunch of them. Her Ph.D. is in informatics. She's a world-recognized informatician tied into the whole government, yah-dee-ah-dee-yah-duh. I said, "You're coming here as dean but your informatics skills we need."

As part of that, we said, "We need to set up an institute for health informatics and bring together the old program and the new, work with Laël [Gatewood] in the period." That's how we created the Institute for Health Informatics. We kind of got sidetracked here with a couple of faculty for a while, but that seems to be sorting itself out now. So that's where it came from. I think it's been quite successful. It needs the right leader.

Then, out of the CTSA [Clinical and Translational Science Award]… We lost the CTSA the first three times, because we didn't have a well-developed informatics infrastructure. The fourth time, we put it together the right way and we got the CTSA.

DT: Which year was that?

FC: Ohhh… I think, actually, it was 2010. It was my last year that we got it. I felt vindicated.

DT: [chuckles]

FC: Initially, it started out and the dean of the Medical School recruited somebody, and it was mainly focused on the Medical School. That didn't sit well, so I had to change the leadership and put together a new team. I brought in Bruce [R.] Blazar on the team and that's how it got done. It was a matter of doing what you needed to do to get where we needed to be. Now, it's one of the best around.

DT: I saw that the first director of the Institute for Health Informatics was Julie Jacko.

FC: I was part of her recruitment.

DT: Can you tell me a bit about her?

FC: Julie is a very, very bright, dynamic person whose primary degree was engineering, whose major field of interest is a hot area now, which is the interface between what's on the computer and the user of the computer. That is a red-hot issue. Part of the failure of the electronic medical record is it was built by techies, not designed by clinicians who have certain patterns of thinking in how they like to see information. How you put the information on the page, where you use graphics, where you don't, where you can use tables was never considered. That's the interface she works on. She came here and did a lot of good work. She had a lot of good grants and, then, this whole history of her and her husband [François Sainfort] and dual employment and what may or may not have happened at the institution she came from… It all got resolved, and in the resolution, she and her husband left. I was gone during the resolution, so I can't give you much information on that.

DT: Can you elaborate on the other stuff, because I don't know that story about the dual employment?

FC: She came from… I'm blanking on it. Georgia Technical University? I'll remember, eventually.

DT: Georgia Institute of Technology?

FC: No. It was the one where there was a big shooting. Georgia Tech, yes!

She and her husband, François… François was an informatician and was in that area of public health. Julie came here seventy-five percent time in the Institute for Health Informatics and twenty-five percent time in the School of Nursing. There were some allegations made that, in fact, they came here on a full salary while they were also achieving a full salary from Georgia Tech. All of that got put together. I can tell you what's in the newspapers; I can't tell you what's in the legal files. That was all public information. There was supposedly a big lawsuit pending in the attorney general's office in Georgia. That got dropped. There was a resolution. There was a resolution here, and they both left. Was there truth in it? It is what it is. I don't know.

DT: I remember that was happening the first few weeks that I was here. It may have been when I interviewed here because I couldn't meet with you because…

FC: It was at the same time.

DT: …this was happening.

FC: That's about all I can say about that.

DT: That's fair enough. I just knew that there was some controversy that someone had warned me about.

Then, Connie Delaney was appointed as interim director and has been since that time?

FC: Yes. Again, the University program has kind of not developed very well, but the program in health sciences has just blossomed. I think there are probably half a dozen faculty now in Informatics. They are searching for a new leader, and it's recognized for what it is.

DT: From the predecessor of the Institute, it's been interdisciplinary and interprofessional from very beginning.

FC: Yes, very much so.

DT: Nurse informaticians from…

FC: Nursing, Pharmacy…

DT: Public Health.

FC: Medicine.

DT: Let's leave it there and we'll set up another time to do the final round.

FC: Okay.

[End of Part 2 of the interview.]

Interview with Doctor Frank B. Cerra, Part 3

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed in Doctor Tobbell's office in Diehl Hall

Interviewed on September 3, 2014

DT: I'm back with Doctor Frank Cerra. It is September 3, 2014, and we're in my office in Diehl Hall. This is part three of our interview series.

I thought we could begin by talking about the decision to sell the Hospital to Fairview and that process. You had said it would be a long question.

FC: [laughter] Well, it's an interesting one. It goes back into the 1980s with managed care and the attitude of University Hospital that it was performing the high-end care and, therefore, could price it anyway it wanted, and people would pay it, and that there was a part of the premium needed to support education and research that went on in the Hospital. This is in the context where the Hospital had a yearly state appropriation to support the cost of education and the educational activities that went on in the Hospital. So as managed care moved along, they began to say, "You know, it's not really our job in the premium structure to pay for education and/or research. That's really a state function or a function of tuition." Of course, the common conception out there is everybody at the University is on the state payroll anyway and why do they need more money. I don't know if we ever got over that—that's kind of another story—in spite of immense educational efforts and those kinds of things.

The Hospital never had more than seven or eight percent of the market. It was mostly this high-end stuff. It had never emphasized primary care. In fact, when the state passed a law to develop family medicine and community health, mainly the clinical chairs here weren't excited about having that inside the University Hospital and have *those people*—in quotes—have admitting privileges and care privileges. That program spread its faculty out into a network of clinics that admit to other hospitals and are affiliated with other hospitals. So that's kind of how that came about.

Oh, I should mention one other factor. It used to be between the private insurers and Medicare and Medicaid that money wasn't an issue. But it gradually became an issue as the purse string was cinched down by the managed care people. They paid less and less.

One example of what went on is in the kidney transplant business, there was a concerted effort on the part of the faculty, and I would say, and the Hospital, but mostly faculty driven, to reduce the cost of that care. They did only to find out that the third party reimbursers in the next year's contract cut back to the lower level of payment. So that incentive was taken away. Of course, that leads to the question of where we are today who gets the cost savings? That's kind of the history of that.

So the Hospital began to experience some financial issues, call them cost overruns, shortfalls, whatever you want to call that. They were no longer in the black. The reimbursement rates were changing because the premiums were pulling out anything for education and research that were charged to the people in the plans. At the same time, the Hospital was beginning to get more and more control over what it did, but its market share continued to shrink. So in the early 1990s, it became very clear that the Hospital was chewing up its University allocated reserves to balance its budget and that it was in a death spiral and was going to die if something wasn't done.

Bill Brody became the provost at that time. He brought in JoAnne Jackson as his chief financial officer. She worked in the finance office of the University. They began to get

into the weeds on the financials of the Hospital. Because there had never been any real accountability of the Hospital to a University administrator, they kind of were out there on their own and just kind of managing their own finances and contracts. This is at the same time there were eighteen or twenty different practice plans in the Medical School, and I would say the faculty were practicing in a lot of other institutions, so they weren't focusing their whole practice on this. So Provost Brody decided we better really take a look at this and figure out what to do.

So we brought in a consultant. He was from Boston. I'm trying to remember his name. Someday, it will occur to me, maybe when I read the transcript. He came in and he did a detailed financial analysis, a market analysis, and trend analysis of what was going on. He said, "Look, you guys are in big trouble." The Board of Regents got involved in the Hospital administration and, then, the academic administration.

I was dean of the Medical School at that time. I said, "You know, we only have a few options. We can close the Hospital." Well, that wasn't really an option. Another option that came up is can we turn it into a Harvard where Harvard doesn't really own its hospitals? But, people began to figure out while that's true, Harvard doesn't own its hospitals, it does control the appointments and the department heads and the financial models of those hospitals. So it's an own-equivalent, if you will. Thirdly, can we form a public corridor group of Hennepin [County Medical Center], University, and Ramsey [County] hospitals? It turns out that soon after that, Health Partners announced it was buying Ramsey and renaming it Regions. So that kind of blew that out of the water. Then, we looked at merging with Hennepin as an option. It just wasn't going to go anywhere. There were too many differences between the institutions that were non-reconcilable at that time. We considered one more. We'd turn it into an NIH institute hospital, like the research center at the NIH. We ran the financials on it, and they finally said, "You know, you can't support it on grants. There's just not enough money in the grants because they don't cover the cost. Unless you have a source of funding that supplements that, you can't become a research institute."

So, the last option was sell it. Allina came up and came to the table. I led that negotiating group. They had a deal that was just not palatable. They said, "Yes, we'll buy it. We'll close it in three years. In that three years, we'll push a lot of our debt into the operating budget of the hospital so we can defease our own debt. We're not really that interested in teaching and research. We just want the clinical business." So we said, "That doesn't seem like it's going to work."

Then, there was some behind the scenes work to see if Fairview was interested. Fairview had a long history with the University. Carl [N.] Platou, as he built Fairview, always had this vision of having a bridge across the river to the University and having a partnership or, in fact, merging with the University. So behind the scenes—Rick [Richard A.] Norling was the CEO at that time—there was a bunch of conversations that happened. What came out of it was that, well, we do have a mix of values that are the same; we value the same things. Fairview was very willing to support research and education as long as they were able to own and control the hospitals and clinics. The clinics are

hospital-based clinics. That's important to understand. They weren't independent, freestanding. I think you understand what that means. They kind of went with the hospital, but we weren't willing to put the practice plan on the table. So by the time these discussions went with Fairview, we had the plan in place to go to one practice plan, now University of Minnesota Physicians. It was a matter of negotiating the affiliation agreements. There's about 1,000 pages of them. Fundamentally, the University would control education and research right up through governance. We would have certain members on a governing board at a certain percentage. The hospital would run the hospital and we would have management contracts through the practice plan for both the clinic and physician services, so PSA's [Professional Service Agreement] and MSA's [Management Service Agreement]. That opened in January 1997 along with the inaugural opening of University of Minnesota Physicians. That all went through a Board of Regents' approval. There were public meetings. There was testimony in the Legislature.

I remember very vividly one Senate Committee that got very pointed about, well, why are you doing this? Of course, we went through the same history and added another thing: you guys need to understand that without a practice plan and a viable place to practice, the Medical School will fold—that dependency began to come out—and that you really don't pay us salaries. As a clinician, my salary was almost all non-state money, which is true for most clinicians. That money goes elsewhere. They didn't understand that; that was new to them. Then, the question was raised, "What can the state do?" They said, "Can we mandate that people on the state health plan go to the University?" Well, it turned out they couldn't do that because of a variety of reasons. They couldn't do it in the state because there was such a large population of self-insured. It's not that they couldn't. They really didn't want to put any more money into it. So that ended up going nowhere.

The insurance companies weren't willing to come up with a system to pay for education and research. They said, "No. That's all in your lap. You have to figure out how to do that. Now, you ought to get the money from Fairview."

So that's where it came about. It was done in about a year. It was implemented in 1997. Now, it's, what, seventeen years later? That's the story behind that at a high level.

DT: Were there any cultural differences between Fairview and University hospitals when that merger took place?

FC: Good question. Yes, and that's one of the lessons learned. We knew Fairview was, basically, a community hospital culture and the University was a university culture. When it started out, the cultural integration was a recognized issue. We started out with some consultants to promote the cultural integration. Six months later, the CEO of Fairview left and the CFO of the University left. The people who were available were basically myself, Roby Thompson as head of UMP, and the chief financial officer of Fairview. Because of the turmoil, the effort to get these two cultures to begin to talk to each other, develop trust, and work together, failed. In the first couple of years, it got

very contentious. There was a big meeting between Fairview and the University both at the board level and the practice level, a lot of shoutin' and routin' that got people's attention again and began to move ahead on, essentially, figuring out what is the operational interface between a hospital and a university—by university, I mean practice plan as well as academics—that would work. That's where the current structure came from. Now, it's changed a little bit since the new relationship between the hospital and UMP, but that put together a communications and operations interface that really began to work and people began to see that it was in their best interest to stay in this relationship. So the University of Minnesota Physicians just blossomed and have continued to do well. We were able to figure out how to get education done, how to get research done, how to get the IRBs [Institutional Review Board] to work, all of those kinds of things. A lot of that was driven out of the Research and Education Subcommittee of the Board of Governors or Directors—I can't remember what they called them—that I chaired. Actually, it turned out to be one of the better moves that we put into the agreement, because it controlled all that policy. The vision and mission and goals of the University became very much a part of Fairview governance, as well as the administration.

There were another few bumps in the road relative to the new CEO of Fairview. The interim CEO was a good guy but with a community hospital orientation. That led to the recruitment, a national effort, and David [R.] Page came. That went through the governance system. There were a few contentious days but it, finally, worked itself out. The University's needs, admission, vision, and goals were very much a part of the governance. That didn't begin to change until seven, eight years ago for a variety of different reasons.

I think most people feel this was a good thing to do. It definitely helped University of Minnesota Physicians, which, of course, helped the Medical School and the Academic Health Center. There was money that came directly from Fairview into the vice president's office. Then, the management contract over the clinic was set up with UMP with performance incentives and that worked very well. Their market share began going up and up and up, most of which was not Fairview referrals but referrals from other health systems. That's pretty much the way it exists today. Now, the market forces are beginning to reshape referral patterns and payment systems. One can only hope with the new arrangements, they work together to solve the issues, and I think they will.

DT: So what's the structure now? You mentioned that the structure changed between the relationships.

FC: There's a new relationship between University Hospital and University of Minnesota Physicians. I can't remember if it's called University of Minnesota Care or something like that. They're kind of a sub-corp of the Fairview corp. They have a lot of self-management and marketing control. The CEO of the hospital is also the chief operating officer of the system. They're just beginning to implement that. It has its own board that has a certain sphere of control. That's about all I know about it. I haven't really gotten into that. It kind of happened after I left.

I did make a concerted effort to do what most people thought should be done, which is a full scale integration of the Fairview system and the University of Minnesota Physicians into an integrated organization that also would involve a piece of the University. So it became an integrated health system and became the University of Minnesota Health System. But there just wasn't enough time or inclination to do that kind of integration, even though it had reached the board level and was teeing up for a vote. There were too many details we couldn't get done, so it just kind of stopped.

DT: Was there initial resistance or opposition among the physicians and other health professionals in the University about the sale of the Hospital?

FC: Initially, yes. There was, after that initial two, three, four years of resistance, an unhappiness came from, until people began to see that if they made it work, they actually saw more patients, their revenues went up, and they were able to accomplish their departmental-based plans.

It was also the design… [chuckles] You know, the things you do set you up for the future. The practice plan was set up so the chair of the department was also head of the service line and the same person dealt with the finances. That has upsides and downsides. The UMP had to figure out a way to make it work, and they did. It's been, I think, a big success from a lot of points of view—not all.

DT: I know this is jumping forward in time, but while we're on the subject of hospitals… I know Amplatz Children's Hospital opened after you had stepped down in 2011.

FC: Yes.

DT: You had mentioned in one of our previous meetings that it was important to talk about the failure of having a unified children's hospital in the Twin Cities. I wonder if you would speak to that now.

FC: The idea of having a children's hospital goes way, way, way back. The stimulus for that, on most of the records I've been able to dig out, came because everybody felt there needed to be a children's hospital. Now, as it evolved, University Hospital developed a children's hospital, but it was inside the adult hospital. So it really didn't look and act like a children's hospital even though it had separate nursing. It didn't have separate access. It really wasn't governed by pediatricians and those kinds of things. So there was an effort by the community to say, "We really need a freestanding community hospital with community pediatricians." It became a town/gown thing. At that time, you had to go for third party approval to add beds. The independent freestanding children's hospital affiliated with the University's Department of Pediatrics basically failed because the University didn't want it, and the Department of Pediatrics didn't want it. It turns out several years later that kind of turned itself around, and there was approval for a freestanding children's hospital—I shouldn't say it that way—for the addition of

additional children's hospital beds. Then, there was this row. Is it built at the University? Is it built somewhere else? The pediatricians and the academic pediatricians couldn't get together, so, finally, the community said they were going to build what is now the Children's Hospital system that's part of Allina, and they built a hospital.

From that time, periodically, would recycle, "Let's try and put the children's hospitals together into one children's. You had, at that time, Saint Paul kids, which became part of Children's Hospitals of Minnesota, and, then, you had the one down at Allina. Then, you had Gillette. Then, you had the University. There were pediatric services at all other hospitals. We said, "Let's see if we can form a freestanding hospital." It never really happened. The ostensible reason for the first rounds of this was that the pediatric intensive care docs blocked it. At that time, PICUs were very big and very powerful and the Twin Cities was the core referral for the whole Midwest. Some of it went to the privates. Some of it came here to the University. The late Ted [Theodore R.] Thompson, for instance, was very instrumental in the success of the children's neonatal and pediatric intensive care movement, and the establishment of regional centers, and levels of care, and those kinds of things. Then, it would fail. While I was here, there were three attempts that I know of, two of which were during my vice presidency.

This last effort, which we came very close to, failed for a variety of what I would call political and marketplace reasons, not financial. Financially, it would have worked. But if you were going to form a new children's, the question was where would it go? Of course, the site that was chosen was where the new clinic is. Then, Allina didn't really want that. They began to figure out that where the kids go, the women go. Fairview said, "We're willing to throw in our women's to this new independent children's. The neonatologists said, "Well, you know, we don't know if we really want to share that business." It just blew apart again. The only issue I think that was resolved was you could make it work financially. But the political and marketplace issues just wouldn't permit the faculty or the staff votes for governance to make the decision. I just consider that a big failure. I really wanted that to happen and just couldn't make it happen. It was just too big a deal and the community was divided about it. We thought there might be community support, particularly of the philanthropic community, but it never materialized. It only became criticism after the failure. Then, of course the blame game and all that kind of stuff. It just didn't happen. I thought it was a big problem.

Then, the opportunity to separate the Children's Hospital of the University Medical Center into what is a separate children's hospital but contiguous with came up. There was a private donor. To my knowledge that's been very successful.

DT: You were appointed provost and then senior president in 1996 and you held that position until 2011. I wonder if you could speak to what you considered to be the major challenges and achievements of that tenure.

FC: Well, from 1997 until about 1999, I was provost and dean of the Medical School. Then, with the change in University administration, provost was renamed as senior vice president because [President] Mark Yudof didn't want three provosts, and I don't actually

think that worked very well. So he eliminated one of them. There was a senior vice president for health sciences and, then, the provost of the Twin Cities campus, who was also a senior vice president—or was he called the executive vice president? I can't remember. It was one of the two. Then, [President] Bob Bruininks added another one later on for a variety of reasons. I held that position as senior vice president—I've got to get this straight now—until 2008, at which case President Bruininks wanted to combine the positions of senior vice president and dean of the Medical School into one position, which, I, again, did…

DT: [chuckles]

FC: …until I officially stepped out of those positions in January 2011. It was a long time. It was long enough that some of the decisions I made came back and needed new decisions.

DT: [laughter]

FC: During that time, forming the single practice plan and its success happened. The Fairview/University relationship happened. We resolved the federal lawsuit over grants management and put in the new grants management system. I did that with help from other people. I was the team leader. There was a major effort to unionize the campus, mainly because of the clinical faculty in health sciences, that never made it. There was all of the business of creating success in the Fairview relationship. That was at the time when I needed to get the Academic Health Center and all of its units moving in the same direction. This was the development of the first strategic plan that everybody signed off on. It was done in a way that was first school-based and, then, we mixed people from different schools. Out of that came the Interprofessional Education and Clinical Practice and Research, which is now coming to fruition, and the need to get the operating system between Fairview and the University and UMP working. It's where we began to come to grips with improving the status of the Medical School, which, about that time, was [ranked] about thirty. I think I finally got it up to twenty-four or twenty-five. But it was impossible to get the investment you needed, and we became facility bound. We didn't have the room for the faculty. That's where the whole idea of what is now the Biomedical Discovery District came from. It took four, five years to get that done. That's now done. The last remaining piece of that is the development of the science park, which is a piece I'm still working on with community leadership and the business sector. So there's all of that stuff. Calming the place down, getting it moving in a common direction, the success of interdisciplinary research… As the University's portfolio grew, it really grew in the interdisciplinary research pieces. That's what held us in the ballgame. While everybody else was contracting, we were, in fact, increasing our sponsored project budget. That's all I can think of.

DT: That's quite a lot.

FC: It was a very, very active time. I think it only happened because being senior vice president and having all the deans and all the schools reporting to that position, you could

get the resources, responsibilities, accountabilities, and direction aligned and hold people accountable. You could put in payment systems for deans that were dependent on annual reviews and salary adjustments. You could get all of that kind of alignment so you could begin to move a common agenda forward. A lot of what was in the Academic Health Center in the Education Department and so on and so forth came out off the top of the dean's money voluntarily. So they put it into place and it served everybody well. It was out of that that the School of Allied Health began to form. That was another big development. That's kind of stalled. I don't know where that's going to end up. We're going to have to wait and see about that. I don't know about that. Then, I had set up the faculty governance system for the Academic Health Center, which came out of the University's governance system by election, not appointment.

In 2000—I think it was 2000—I recruited Barbara Brandt to head up Education and solved a lot of the problems we had, for instance, the affiliation agreements. There were like 1500 or 1600 of them, mostly different. We had to begin to verify that the students understood HIPPA [Health Insurance Portability and Accountability Act], that they had their vaccinations. She set all that stuff up as part of her job. We didn't have a real promotion and tenure process. We didn't have a process for the approval of new professional degree programs. She set all that up and, in addition, began what is now the Interprofessional Education that's moving along nicely in the University at the state level and in the national center that we were awarded. So that's another big piece. I'm actually quite proud of that, and I continue to work on that.

DT: It seems a lot of things are coming to fruition that were initially intended when the Academic Health Center was originally created in 1970.

FC: That's correct. Finally.

DT: Yes. It seems like there were, especially in interprofessional research and education, examples of that much earlier but it just wasn't…

FC: It was on the margin.

DT: Yes, it was on the margin.

FC: When Barbara came here, I'd done a lot of groundwork and had it in the strategic plans signed off by the faculty and the faculty governance. She and I just said, "Are we going to keep working on the margins? No. We've got to drive to the core and get it really part of the culture." That takes a long time. Now, ten, twelve years later, it's getting there fast. It takes that long.

DT: When there's a lot more interdisciplinarity, interprofessionalism, it's much more in the minds, I think, nationally, too.

FC: Yes. A lot of faculty fought it. Then, they began to see the wisdom in it. I think starting with research made it easier for people to see. The NIH played into that. If you

didn't have interdisciplinarity in your grant, you usually didn't get funded anymore, even at an ROI [Research Project Grant] level. I think people began to figure that out.

Oddly enough, the last piece to begin to see that is the clinical piece. That's basically being forced by the marketplace. As the marketplace says, "The doctors, nurses, et cetera, that you guys graduate, we have to spend two or three years retraining. We don't want to do that anymore. It costs us a lot of time, a lot of money. They don't know teams. They don't know informatics. They don't know systems," so on and so forth. That's really forcing a big change, as is the Affordable Care Act, and changes in financial reimbursement.

DT: In 2008, 2009, when your position was then merged again with the deanship of the Medical School, how did you feel about that restructuring of your role?

FC: Actually, my position has always been, for what was at that time, a $1.8 billion enterprise, a billion of which was the Medical School, it was preposterous to think that one person could manage the Medical School and the Academic Health Center and continue to get the alignment of mission, vision, values, and practice that were necessary to meet the demands of a reformulating healthcare system and to actually grow as individual schools in stature and so on and so forth. By having academic reporting to the provost's office and saying, "Well, the vice president is responsible for all the interprofessional work but without any authority or budget doesn't make any sense to me. It never did.

So I argued against it. I am one of these people. Bob [Bruininks] was the boss. He made the decision, and I had two choices: either resign or do it. So I said, "Bob, I'll do this, but I think it's temporary." Then, he decided he was going to retire, so he said, "That decision will ultimately be made by the next president." I said, "Look, the way I'm going to set this up…the only way I can see to do this is, yes, I will be dean, and I'll be vice president, but I will work at the administrative policy level. I will then have a chief operating officer"—which turned out to be one of the best in the business, Mark Paller—"who will run the day-to-day operations of the Medical School." That was a very effective model. Again, it was a culture issue with the chairs, because they had had over 100 years of the dean's ear. Well, now, they had the senior vice dean's ear and, then, the dean would get involved in annual meetings, annual reviews, and major policies but always had an open door policy. It was very effective. It worked very well and is, fundamentally, what still exists.

I think there was outside influence in the decision to recombine the two positions. There really isn't anything you can put your finger on that says that's the standard. But my point was for an academic health center of this size and stature—there are only another two or three that match it—it's a nonsense kind of organizational structure. You're beginning to see it unfold. Getting the alignment around interprofessional work now is kind of much more difficult for it to happen. I think that's going to have continued consequences. There isn't as much camaraderie and joint decision-making amongst the deans, so it's not clear how the new professional degrees get done, what happens with

disciplinary actions, what's the role of the vice president for education in the Academic Health Center. It's all of that stuff. I think a lot of this had to do with some consulting people who convinced the president that you can make any organizational structure work. Then, there were some other goals. I think a lot of people felt the Academic Health Center was too big and too influential in the allocation of resources and what went to the state for funding and that it just, frankly, had too much power, and that they wanted to fix that, but never really thought through the consequences of actually fixing that. I think that's what's unfolding, which I think is unfortunate because this was, if not *the* premier, one of the three or four premier academic health centers in the world. I think it's lost a bunch of that.

I also do not think people understand what it's going to take to move the Medical School ranking, which is a research ranking, up into the top ten. When I calculated the need for that, it was $200 million to $250 million of new faculty salaries that needed to be invested. The buildings, we've got. But it's the faculty that make it happen. I just don't see where they're going to get that money. The practice plan revenue is not going to keep growing. It's going to be under more and more pressure and so on and so forth.

DT: The problem with the merged positions is that goes back to what the Academic Health Center was created to avoid.

FC: That's correct and was clearly stated by what the Regents approved and the reasons for it.

DT: Yes. Did you feel what the attitudes were of the other deans and the faculty when that announcement was made that the positions would be merged?

FC: Here's what it came down to, I think. There was some concern on the part of the president that the job was doable. They knew I was doing it. They thought I was some kind of master brain—which isn't true. You can learn what goes on. It's not magic. You just go visit them and get to know people. There's a learning curve. But they didn't think they could find any one person that would take the job, which I knew was not true because I had polled a bunch of people that I knew would take the job and who were salivating for it.

DT: [chuckles]

FC: The other two arguments were… It was actually the deans who were saying, "Frank, we're fine with you as senior vice president, but we don't know what a new person is going to do." True statement. "But, you guys are going to be involved in the selection process, and it's up to you to see that that doesn't happen, that somebody is going to play fair just because I'm an M.D.," and so on and so forth. That was another argument that was put forward. Of course, at the time, I was vice president/dean, and they thought that was a little too close. The Medical School recycled an idea that came out in 1970, which is the dean of the Medical School should report directly to the president.

DT: Ohhh.

FC: [chuckles]

FC: There's actually a couple of documents about that in the formative stages.

So we got what we got and you then you try to make it work.

DT: I wonder if you could talk about the Clinical and Translational Science Institute. Were you involved in getting that, the CTSA ?

FC: Yes. That was an effort that I started, initially, with the dean of the Medical School who had recruited somebody she thought would help manage that.

DT: Deborah Powell?

FC: Yes, Debbie Powell was the dean and… I'm blanking on his name. I'll remember when we do the transcript.

So we put the grant together, and it went in. It was turned down. It was turned down because it was too Medical School centric. It was not interdisciplinary enough. It didn't really have an informatics program and just wasn't up to snuff overall in its educational programs. We tried to fix that, and it was recycled again, and it was turned down for the same reasons. So I said, "Okay, we need a whole different tack." So I put together a whole new team, put Bruce Blazar in charge of it, came up with a whole other development team. At that time, we had made the major investment in the Academic Health Center and University-wide informatics programs. Connie Delaney was being recruited. She was dean of Nursing but whose major degree is in informatics and who is a national and international figure in informatics. We redesigned that program to get the Institute for Health Informatics. We put in some degree programs and put our major investment in developing what is now the Information Exchange, and beefed up the education program, and submitted it. That time, they came back, and they really liked what they saw, but they didn't yet like the informatics people. They didn't think we had true informaticists leading it. So, we went back, and we changed that, and, then, we got the award.

DT: [chuckles]

FC: I credit a lot of that to Bruce Blazar and his ability to pull people together and get it done. It was really extremely well done. We got that announcement just after I left the office, but it was submitted under my regime. I'm glad you brought it up. I'd forgotten about that. That was a big deal. It actually set the stage for the National Center for Interprofessional Practice and Education and the establishment of the national database and the research network to show whether IPE works or doesn't work.

I think that's right. I think a lot of what's happening, you know, is you build on the shoulders of the people before you. In my case it was undoing a lot and, then, redoing it, and building a solid infrastructure, which is my fetish. I really am a nut on infrastructures, so that whoever took the reins could make it happen. I was foolish enough at one point in my career to say, "If I finish these six things, nothing else needs to be done."

DT: [laughter]

FC: Then, I tried to make an orderly transition by saying, "Okay, over the next year, here's what I'm working on. Here are the six things. Here's what I hope to accomplish. In the meantime, you guys need to get together and start figuring out what is the transition plan going to be, and how you're going to work with the president's office, and so on and so forth." I was going to resign. Then, Bob [Bruininks] decided he was going to resign. We said, "We need to stage this," because whoever takes my position wants to know who the president is. So that was supposed to come first and, then, mine, but the Board of Regents changed all that. They just decided they were going to do it on their own timeline, so I just said, "Look, I'm done the end of December. I can't wait any longer."

DT: We still have a couple more minutes. I wanted to know a little bit more about the Biomedical Discovery District. Does it have any relationship to CTSI, like the technology transfer issue?

FC: No. It's a freestanding independent idea. Its framework was around the development of new innovative knowledge that can be commercialized and support the private sector. It was paired up with the development of this science park, which would be privately owned and operated where the tech transfer would occur. The rubric around it, which was true, was that the State of Minnesota is going to become a flyover state for high tech. If you don't want that to happen, we need to do something. The only place you can really make this work is the University and here's what we need. That was the concept. Then, "Fitz" [Richard H. Pfutzenreuter] who is very creative financially, thought about the financial plan to develop it. That is partially issued by the University, partially by the state, but it's guaranteed by the state. That was the basis for the Biomedical Discovery District. We were able to promote it so it became a bipartisan effort. [Tim] Pawlenty, when we started this, was the majority leader in the House, and then became governor, and by the time this thing got to the final approval process, Mayo voiced it's support, the deans advisory group voiced support, the state voiced…everybody was behind it. That's where that came about.

DT: It seems to fit well given that we already have medical device alley.

FC: Oh, yes.

DT: We already have a big med tech industry here.

FC: Absolutely. That's another thing I did a lot of work in. Medical alley became life science alley. I was chair of the board during that as it merged with the biotech industry into one and changed its focus to one of promoting new company formation and those kinds of things. That was kind of exciting. It was very useful to me in figuring out what was possible and how greater Minnesota would benefit as well as urban Minnesota. That was part of the story that needed to be told.

Along there was another big deal that happened which was the formation of the University/Mayo partnership in research. That was something that came out of a meeting with Hugh Smith, who was the CEO of Mayo at that time, and myself as senior vice president. We were sitting at a quality and safety meeting and said, "We really need to work together." And we decided to do that. We formed this partnership, which ended up getting about $100 million of state money, got a building addition down at Mayo Clinic. It's been a huge success. I forgot about that one. It's still ongoing. I think it still issues $7 million to $8 million a year in grant funding. It's been very successful. It's hard to know when you start a ripple where it's going to go.

DT: There are a lot of ripples that you've started. [chuckles]

Any there final things that you want to add to the record?

FC: I think you've covered most of it. There's a lot of detail, which will end up in the book, which is probably the appropriate place for it.

DT: Yes. [chuckles]

FC: No, I have nothing to add. I thoroughly enjoyed my time in senior University administration. I learned a lot. I think I contributed—I think it's a different place than it was when I started—and have laid a solid foundation for Doctor [Jay Brooks] Jackson to continue to develop it. That's what I think. My only wish is they would split the two positions. Then, I think they would serve well this University, and this Academic Health Center, and the State of Minnesota.

That's it.

DT: Thank you. That's great. Thank you.

FC: Thank you.

[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