UFHC 57
Interviewee: Warren Ross
Interviewer: Nina Stoyan-Rosenzweig
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S: This is Nina Stoyan-Rosenzweig, I'm interviewing Dr. Warren E. Ross in Philadelphia at the Drexel University College of Medicine, and the date is August 2, 2002. Dr. Ross, I guess we can just get started by asking you when and where you were born.

R: I was born in 1948 in Detroit, Michigan. My father was going to school, he was getting his master's degree, [while working] at Chrysler at the time. I guess we stayed there for a couple years and then we moved to Nashville, Tennessee, where I lived until I was about thirteen. [Nashville is] where my father first ran a gas station and taught a few courses on the side at Vanderbilt, then became a full-time faculty member, and then, in 1961, he decided to get a Ph.D., which was becoming increasingly the thing to do in engineering. [We] moved to Gainesville to attend the University of Florida Engineering School. I lived in Gainesville for four years at that point, then moved to Tampa for one year, and then immediately returned to Gainesville in 1966, on graduation from high school. I actually moved back to Gainesville about three days after my high school graduation, by myself, and went to work at Shands Hospital as a nurse's aide up in the pediatric floor, back in the old building. My mother had actually been a director of End Service Education at Shands back in the early 1960s and had helped me get that position, and I worked that summer as a nurse's aide and then entered undergraduate school at the University of Florida in the fall of 1966. After my first year, I actually was introduced to Dr. W. Walter Oppelt, who was professor of pharmacology and medicine at the University Florida College of Medicine. Dr. Oppelt was a pharmacologist, [but] he also did cancer chemotherapy, which in those days didn't even have a name. It later became known as medical oncology. It was largely because of Dr. Oppelt's mentoring, which extended through medical school really, that I became a pharmacologist and a medical oncologist as well.

S: I noticed that a number of your early papers were published with Dr. Oppelt.

R: Right, we published papers while I was an undergraduate and then as a medical student. When I was a freshman medical student, he actually had a brain tumor. I thought he wasn't going to recover at that time, but he did make a recovery. Then, later [he] left the University of Florida about the time I was graduating from medical school and, unfortunately, died a year later with the recurrence of the brain tumor. He was probably the most influential person in my professional life. [He was] an extraordinary individual and it was a formative time of life.

S: Well, I guess some of the questions I was going to ask you just had to do with

who were your mentors as an undergraduate, and I guess he fit both in that category as well as during your medical school career.

R: Yeah, he was clearly the most important mentor to me. I was fairly independent, probably pretty strong-willed in retrospect, and he was somebody that was comfortable giving me clear direction and suggestions, and not doing it in a way I found offensive. So, he was very good for me, [on a] personal and professional level. He helped me with the decision to go to the National Cancer Institute for my fellowship. Really, I went there to do research more than anything. It just so happened I needed to do a clinical fellowship too, so I decided to do oncology. He was instrumental in that and a number of other things.

S: It sounds pretty clear that as an undergraduate, you were already focused toward medicine. When did you first decide? Did that happen earlier, or did you go through high school knowing you wanted to [be a doctor]?

R: Yeah, I was one of those people who had thought that I was going to be a doctor, knew I was going to be a doctor, never considered anything else from the time I was probably eight or nine years old. My mother, as I said, had a nursing background. She used to tutor me in the summers in anatomy and physiology and she was, certainly early in my life, I guess like so many people, she was the biggest influence in many ways. [She] still has some influence, [although] probably not as much as she'd like. I made the decision very early on. Now, I have to say that it was not an effortless path. I did well in school until my eleventh grade, and then really didn't do well. Then, my parents moved and, lo and behold, [I] was not subject to the same influences I was subject to. In the eleventh grade, I suddenly did very well, and I did very well in college and the rest of it sort of fell into place rather quickly.

S: Well, it looks here as if you started as an undergraduate in 1966 and graduated in 1969. You went through in three years?

R: Well, I didn't graduate. Actually, back in those days, there was no program for getting into medical school, really, but the Medical School did accept a very few students after their third year, so without an undergraduate degree in effect. I applied to a number of medical schools. The one I got accepted to was the University of Florida. Of course, I was very happy to stay there anyway. I had a girlfriend. I had a job. I didn't know what more there was in the world. I was very happy to stay and I've never regretted staying; it was a great decision on my part. My junior year of college, which was my last year of college, I spent a goodly portion of it working in Germany with Dr. Oppelt. [He] was of German background and periodically did sabbaticals in Germany. I did research in Germany. So really, I didn't even do a complete third year of college.

S: I'm interested in this, so I'm going to ask a question, as the arc of this stuff is supposed to be able to answer about the early cancer research at Florida. Was Oppelt the first person who started all of that, the Cancer Center and that sort of thing? Did his research help that take off?

R: No, Dr. Oppelt really did cancer chemotherapy as a clinical pharmacologist. His laboratory research actually had to do with the rate of fluid formation in the eye and in the spinal group, and the influence of drugs on that. His cancer chemotherapy was just a clinical outlet, it was not a research interest at all.

S: Was he working then with Dr. Marin?

R: Yes, he was recruited by Dr. Marin**,** because they had common interest. Dr. Marin tended to recruit people that he thought would be helpful to his program.

S: When you said fluid accumulation, that certainly rang a bell.

R: Right, they had worked together up in Maine. Dr. Oppelt had worked on shark spinal fluid, and caught the attention of Dr. Marin. Dr. Marin recruited him to Florida.

S: Did you do any other research in Maine or anything like that, or were you focused on the cancer?

R: No, I never did any research in Maine at all. I thought about it, but, by then, Marin was going up there every summer, but Oppelt wasn't. I didn't want to go with Dr. Marin; I wanted to be with Dr. Oppelt.

S: Can you describe your medical-school experience, course work, that sort of thing?

R: Sure, I entered medical school in 1969. It was a bit of a time of change in many ways. Of course society was changing pretty dramatically: the Vietnam War was very much an issue, there was student unrest, and student empowerment. It also was the first year of an entirely new curriculum at the Medical School, one that, as I look back on it, even now, was, I think, quite innovative, and probably well worth implementing today. That was a new curriculum that had been led in its development by the dean then, Manny Suter, and **Parker Small**, who was at that time the Chair of Microbiology and Immunology and a fairly well-known educator on a national level. The curriculum was intended to get the basic sciences done in less than two years, just a little over a year really, and then get the students out into the clerkships right after Thanksgiving of their second year, which was about eight months earlier than historical[ly]. Then, bring them back to do some basic sciences after they had done their clinical period. It suited me

very well.

First of all, I learned relatively quickly. I think I had the highest board score. When we took the boards, I think actually I was close to the top of the class, if not the top of the class, at the end of that basic science period, which we called Phase A. The other thing they did was, they limited the time in the classroom so that I could do my research. When we came back in Phase C, the third part of this, it gave me a lot of time to do research in addition to doing the expected clinical things and classroom things. So, it was a curriculum that worked well for me. I think it probably worked well for most people, to be honest with you. I was active. I was the student-body president the first two years, the first year of class, and then there were two presidents in the second year. I was a fairly activist kind of guy. I remember, at one point, I was on the plaza of the university, giving a speech to the students about how we medical students supported their anti-war efforts and would be pleased to give them physicals that would help them get out of the draft, which was still very much an issue then. I came back and, a day or so later, the word had gotten around about this and a number of members of my class had posted a thing on the wall that was a petition to impeach the president. While I might have been activist, like many medical students today, they weren't. They were just good, soon-to-be Republican guys. They weren't having any part of their class being tainted with activism. I survived that for one more year and then gave way to more traditional people to run the class.

S: How did you get elected then, if you were more [activist]? Did they not realize at the time?

R: Oh, yes, I think I got elected because I probably stood up quicker than anyone else and nominated myself. I don't know how I got elected, but I did. Then, I got reelected, but they insisted on having a co-president so, just in case I got out of control, there was reserves or something.

S: As an anchor.

R: Yes.

S: Well, you do see, for instance, if you look at the class pictures of the students, there's a period where suddenly everyone's hair gets long and sideburns get long. I guess the medical students to a certain extent were moving with the times, but generally they were more conservative.

R: Well, yes, medical students are always more conservative than the general population. They still tend to come from very wealthy homes, many of them. Many of them, probably twenty-five percent at any given class, are the children of

physicians, actually. So, they tend to come out of somewhat more conservative surroundings. In medical school, probably, because of the regimentation, the commitment of time that's required, and the discipline that's required; [it] doesn't necessarily suit everybody. You've got a lot of interests and you've got to be very good at managing your time in order to go to medical school at the same time as the other things.

S: Was there much activism on the campus at Florida, generally?

R: Yes, oh, yes. It was a very busy time. I find it so interesting now, some of the guys who were university presidents back then are now senior politicians in the state of Florida. I remember them [from] back then.

[interruption from phone call]

S: You were talking about presidents are now senior politicians in Florida.

R: Yeah, but I'm blanking on the names. Let's go on to the next segment.

S: New curriculum at the Medical School, how long did that last?

R: Well, I think the new curriculum only lasted three or four cycles, three or four classes, so seven or eight years at most. It was pretty demanding. The thing about new curriculum at medical schools is that there is a lot of work. When people get excited about ideas, they can be galvanizing moments for medical schools, we've been through some of that here, but they're hard to sustain, because they frequently require extra effort that's not factored into all the other things that faculty do. So, at the end of the day, they tend to always gravitate back to things that are relatively easy to deliver, mass lectures and that sort of thing.

S: Did they ever do any studies to see if that was more or less effective? That seems like a problem with education in general. The people get ideas and then don't really say, well, does this actually work?

R: You'd have to ask Parker Small, he would know the [answer to that] question. I think he's still around. I think they did do some studies, but I don't know. I think what ends up happening, 'cause this is still going on even in my own medical school in Drexel. We have two curriculums simultaneously. When you enter our medical school, and I'm about to visit just a little bit in our class, you have a choice of the first two years. You either have a problem-based curriculum that is totally small-group and student-driven, or the big lecture series for two years. We've tried to look at that in terms of which one is better. I think the answer is that neither are clearly better. The students are so bright that get into medical

school that the curriculum is probably not a major factor in their performance. They can overcome almost anything we put in front of them. They end up doing fine. If they are motivated to work, they'll do fine.

S: Can you talk some about your early research, as an undergraduate and then in medical school?

R: Yeah, initially, the first research I did really had to do with looking at the rate of formation of fluid in the eyes of cats. It involved extravagant experiments where you'd come in, you'd anesthetize a cat, and set him up in a **stereo-tactic unit** where their heads were absolutely immobile, and then you would put two needles in the eyes of the cat. You had to do it very carefully, so there was no bleeding. So basically what you were doing was measuring the fluid formation, the circulation of the fluid, in the eye. That experiment would go on most of the day and then you'd terminate the cat and count the data. Then, Dr. Oppelt's interests changed. He got interested in drug metabolism. This was when we were just beginning to understand how drugs were metabolized in the liver. So, we did some experiments on the effect of different things on drug metabolism. The first work that I can honestly say was my own idea actually didn't have anything to do with either one of those two things. It came out of a patient I saw, when I did my medicine clerkship, who had asthma and who didn't seem to respond very well to the normal drugs for asthma. I was looking at the phenomenon of what was the basis for this. There was a new metabolic intermediate called **psyclocae MP** out there, and we rigged up an experiment with guinea pigs where you'd box [them in and] you'd spray in anti-histamine. They're very sensitive to histamine. So, they would go into **bronco-spasm** and flop over. You measured the time before they flopped over gasping for breath. We would inject them with various drugs to see which ones worked to prevent the bronco-spasm. We did come up with **pscylocae MP** was involved. So, that was actually a fun experiment. That was one that was my own idea that I took from a patient and put it in the lab; something that doesn't happen nearly as often as it should.

S: Just in terms of students doing research while they're in medical school, you mean, or coming up with the research ideas from patients?

R: No. First of all, this is back in the time when there was a lot of money around for research, so you could afford to fund this, even though nobody else was paying for it. You could use those other research funds. That's more difficult to do today. In the first place, neither faculty nor students frequently had the time or took the time to make an observation in an individual patient, come up with a hypothesis of that, and then go back to the lab and test it. Some of it is, quite honestly, the techniques have gotten a lot more sophisticated. It wasn't very

difficult for us to rig up this box and spray the guinea pig, but the way you do experiments now, the technology is so much more sophisticated that it requires a good bit more to scale up and get it done. Faculty's time isn't as protected.

S: I would wonder, too, about using animals in terms of whether it was easier then. I mean, I've seen photos of the animal-research facilities. They were very open and there's no security involved.

R: Oh, no, there was no security, and there were no animal committees or anything else. You did whatever you wanted. I remember we did some experiments on rabbits one time and we took some of the rabbits home and cooked them. It was just a different era.

S: Well, Dr. Cade was kind of famous for the rabbits, wasn't he? He would autoclave them and then have people come in and eat them when he was working.

R: It would not surprise me in the slightest. Dr. [Robert] Cade was unusual in many respects.

S: I've heard stories about them going in in the afternoon, it was when he was also head of **Beer-Hopping Deer Gators**, was that when you were around?

R: Yeah, actually that was later on. When I was a medical student, I remember I had nephrology as a clerkship with Dr. Cade. I can remember and I see this so perfectly as I'm sitting here. You go down to his office, it was in one of those little warrens on the ground floor that was rigged up with very low ceilings and wood paneling that was fairly cheap. He had a dart-board in there, and at the end of rounds on Friday, he would make up whiskey sours. He would drink whiskey sours until dark and talk about stuff. He was one of those people that probably [was] a real genius in many ways. In the end, he was probably was a little more eccentric than the system would allow. He got into dialyzing schizophrenics and the world wasn't ready for that.

S: Well, I wonder, too, you obviously weren't there in the first ten years of the Medical School, but whether it was still small enough and informal enough for students to get involved more easily in projects.

R: Oh, it was; there's no question it was. Our class size was sixty-four. There were a lot of faculty, clinical and basic, who were doing **venture-search**. When I went in Oppelt's lab, there were probably five or six other students that had worked in the lab the year before. In fact, this was a year or two prior to my time there, there was actually a requirement, at one point, that the students do a research project and write a dissertation-type paper in the earlier years of the

Medical School. There's no question there was a lot more research. I don't want to say there was more research then than there is now, but I wonder how much student research there is going on now. But it was a smaller institution and everybody knew each other, I think, a lot better. There were very few buildings there. There was really only the one major building. [There was] a lot of green grass. We used to play football out behind the Medical Science building; you can't play football there now. There was a basketball court and hand-ball courts. It was a very different era. When I was a kid, I used to ride my bike up there. I could ride my bike up there and wander all throughout the Medical Center. I'd go down to the basement, I got through [the] morgue and nobody stopped you. It was just a wide-open place.

S: Did you start out with an interest in cancer or did that evolve as you were doing research?

R: No, that was totally accidental. I wanted to research. I determined with Dr. Opelt that the best place for me to get more research training was the National Institutes of Health. I sort of thought either cancer research or endocrine research, and I got a much better set of interviews in the Cancer Institute and I really enjoyed it, so I decided I would go to the Cancer Institute. Since I was going to be there anyway to do research, I thought I'd go ahead and do my clinical fellowship there. [It's] probably a stupid reason to do it in some ways, but I loved it. I was glad I did. It was a new field and just opening up. I enjoyed taking care of cancer patients, and my research fit with it. I had ten or twelve years as a faculty member as having good funded research and [I] did some important things.

S: I'm going to just go through your post-graduate training. The fellowship sort of postdated your internship and residency. So can you just tell me about the internship?

R: Sure. Like a lot of people, I had lived in the South all my life and then decided I wanted to continue living in the South. So, I looked mainly at schools in the South. I got accepted to my first choice, which was the University of North Carolina in Chapel Hill, which was considered one of the better medicine programs in the country at that time and I suppose, in some ways, still is. Chapel Hill was an idyllic place to live, as it probably still is in some ways, but it was very small then. The Research Triangle was just getting started. It was mostly highways; [there were] not that many buildings at that time. Now there was a lot more buildings. I loved the two years there. It was a great medicine program. It was an adjustment to some extent. I never really loved authority, and I never really loved structure. I had my share of difficulties with this throughout my career. When I was on OB [obstetrics], which was my very first clerkship back in medical school, the two chief residents were Vietnam veterans,

[and] I was a rabid anti-war person. I also didn't love the regimentation and some of what I thought was sort of silly rules associated with the OB clerkship. We got into all kinds of difficulties. I actually ended up making a D in that rotation. I think that was only because they didn't want me back. I did okay on the test, but all my subjective evaluations were pretty negative. I think Smiley [Hill] probably somehow probably got me the D. Fortunately, I went on to do very well on everything else, so it wasn't career-threatening. When I went to my internship and residency, it was much the same. It's a very demanding lifestyle. I had to do a lot of growing-up during that time like everybody does, but in some respects, I think partly because I was younger and partly because I was just less mature, it was a challenging period. I loved Chapel Hill. I then went to Bethesda, the NIH, and that was unbelievable. Not only was it the NIH, which was like many of the greatest scientists of the world were like down the hall, and everybody there was there just to do research, whether it be clinical research or basic research. They weren't there for the money. Everybody just had this excitement about their purpose in life. It was a very stimulating time, and on top of that it was Washington. It was Washington in the immediately post-Nixon world, post-Watergate world. It was a very exciting time in a very exciting town. I mean, Washington was incredible. Here I was, some bumpkin from Gainesville, Florida, and I was going to embassy parties, going to great restaurants, I had money, [and] I was making $40,000 a year, which was unbelievable. So, it was a good time. Those were three great years.

The first year was all clinical. It was very demanding. For the first six months, I did pediatric oncology, which I hadn't been trained for pediatrics, but that's where the leukemia service was. Probably, in some ways, [it] tested my emotional mettle as much as anything I've every done to this day. [I experienced] a lot of growth around then. I did medical oncology and then went in the lab for two years, which was just glorious. I got very lucky and made some important observations that really carried through my entire research career. I ended up discovering the mechanism of action of a very large group of anti-cancer drugs that are very commonly used. Ultimately, it led later in my career to being part of the new anti-cancer drug. It was an exciting time. So, I stayed there for three years and then was trying to decide [where to go]. I think I probably could have stayed there actually. They probably would have been happy for me to stay on, but I was ready to get on with the real world. I talked to several different places. I thought about going back to North Carolina, I thought about going back to Florida, [and] I ended up going back to Florida [and] joining the faculty.

S: This was in 1978 here at the NIAH, from 1975 to 1978?

R: That's right.

S: Let me just ask, your residency was in medicine?

R: Internal medicine, right.

[interrupted by phone call]

S: Let me just also ask, did you have any draft issues?

R: Well, I was a student.

[interrupted by phone call]

S: So, you were a student at the time and that didn't come up as an issue of any sort of Selective Service?

R: No, I had one instance where they sent me a **1-A** or whatever it was. It's funny, but I don't remember getting all that excited about it, but my father panicked. He ran around like a crazy man. Eventually we got it changed back and they recognized that I was a student [and] I got my **2-S** again. The irony of all that was, when I got accepted to the NIH, you actually are accepted into the Public Health Service, which is sort of a semi-military kind of thing. They rejected me initially because I failed my hearing test. So, I may not have been draftable anyway. As it turns out, this is just one of those things, I had been treated as a kid. Because I lived in Gainesville, I had been treated as a kid at the University of Florida by George Singleton. We found the old **audiogram** from when I was twelve or thirteen years old and had recurrent otitus. It looked exactly the same, so we could say to them that, while it was abnormal, it was stable, [and] they accepted me.

S: What was your salary as a resident like?

R: My recollection is it was around $6,000 or $7,000.

S: I guess, as usual with residency, you really didn't have time to do any research or anything like that.

R: No.

S: Was that part of the adjustment, then, in not being able to do research and just focusing on the awards?

R: One of the things that's nice about research is that it's not quite the same. It's demanding, but in a very different kind of way. You have a lot more personal freedom when you're doing research. I think that it probably was a little bit of an issue. You just had to be there, and there wasn't any substitute for being in the

hospital; you had to be there.

S: You couldn't go into the lab and space out over your guinea pigs or anything.

R: No.

S: During the clinical period of your fellowship, you said that the first year was basically clinical?

R: Yes, the first year was clinical. Six months in the pediatric oncology service and then six months in the medical oncology service. The pediatric piece was interesting, because this was right when bone-marrow transplants were just getting started. Boy, there were some real horror stories. I just never was comfortable with it after that. It turned out not to be terribly useful in the long run. It took a long time to sort it out, but it turned out not to be very useful anyway.

S: These were horror stories that you encountered or just that were floating around?

R: No, no, these were horror stories, patients, that I took care of. They just didn't do well; they didn't do well, badly. Much of it was chronic graft versus host disease, which was a very big problem back then, and somewhat of a problem now. You think there's nothing worse than death, but when you watch somebody literally rotting away over a period of months and years just as their body rejects itself, it's not something you forget. It's almost like a war kind of experience in some ways.

S: These were children?

R: Yes, although the one that probably sticks in my mind more than any other was an absolutely beautiful young man; probably eighteen, nineteen, [or] twenty years [years old]; [who] wanted to be a priest. [He had] Mediterranean features, deep faith, and he was transplanted and just went on to have a very bad outcome. It was very hard to watch.

S: What did your days involve in this clinical period? Basically, you're in the hospital situation?

R: Yeah, it was in the hospital and then we had some clinical base, but they were basically in the hospital. You'd admit new patients and you'd take care of very sick patients, people who were on protocols. Most of the treatments back then we were trying were one form or another of very high dose this or high dose that. People were pretty sick. Leukemics get very sick when they get treated anyway, even today, with infection and bleeding and what not. One of the things that was good was they had a seminar, that all of what we call clinical associates

or fellows had to take, on death and dying. So, we really spent a lot of time talking about it and talking with each other. I feel like it was one of the more important things in my life. When I'm done being a dean, one of the things I would like to do is go back to taking care of dying people. It's a very special relationship that forms; it's not like anything else.

S: Is that something that was dealt with in medical school, and do they deal with now adequately?

R: Well, adequately is a good story. We're still scrambling to improve our end-of-life [seminar]. We just had a task force this past year to look at ways of improving our end-of-life, here, training for the students. Part of the problem is that there's not a specialty of palliated care of end-of-life care. There's probably one on its way, but there isn't right at the moment. So, there's nobody here hardly that sort of wakes up in the morning thinking about doing just that. The oncologists are the people that you would think would do that, but they're not very good at it. They're too interested in pushing drugs and radiation and things like that. Most of them frankly aren't very good at palliated care, which is really kind of shocking when you think about it.

S: When you think of palliated care, you mean not so much doing everything you can to prolong life, but making people more comfortable?

R: Right.

S: Oncologists really are focused on, well, let's kill the cancer?

R: That's their primary focus, yeah. I don't want to speak for all of them, but I've had to say as a group, as a professional group, that should be an awfully big part of it. It's not like they're curing a lot of people. I mean, they may be treating a lot of people, but they're not curing a lot of people. You would think that they would devote a significant amount of their effort to the other end, but it's not what they do.

S: Well, it seems like it's a difficult subject for American society to deal with anyway.

R: It is.

S: There's nothing in their background that makes it comfortable to think about it or talk about it.

R: Right, that's absolutely true. It forces you to confront very uncomfortable questions about yourself and your finiteness. That was a lot of what we talked

about in that seminar. There are very few things in life that you have a class or something like that that just lives with you. That stuff just lives with you. I mean, I think about it all the time in terms of how it shapes the way I view the world and how other people view the world. It's a very big issue that, fortunately for most people, doesn't come to the surface very often because it's very anxiety-provoking, unless you like psychoanalysis or something. Unless you're willing to spend a lot of time at it, you're probably best just to keep it in the closet.

S: At some point, you have to deal with it.

R: Yeah, that's right, you do.

S: You moved on into doing research, was this a three-year planned fellowship where they basically said a year of clinical work and then move into the research wing?

R: Right. I went into a lab that was very busy, a lot of neat people working in it, so you form a lot of new relationships and doing new things. You didn't have to get dressed up anymore, slept in whenever, you worked long hours, but it seemed like a lot of fun. [I would] go to research meetings, and it was very exciting. Plus, it was, again, living in Washington. So now, you're not only living in a great place, but you had time. It was a very idyllic period in a lot of different areas. I look back on it [and] in some respects [it] might have been the best time. I don't know. It was awfully good.

S: Well, it's sort of a post-doctorate. I mean it's similar to a post-doctorate and that often is [the best time]. You don't have teaching responsibilities or administrative responsibilities. What about the research itself? What were you working on or with, or was this working with patients?

R: No, the guy I had gone to work for had developed a technique for measuring DNA damage. DNA damage is not only important in terms of causing cancer, but it is the mechanism by which many drugs kill cancer. We were looking at different, important kinds of chemotherapy drugs and how they actually kill cancer cells. [I] just happened on an observation about a drug called **Adriomiacin**, which is still today one of the most commonly used drugs, and found a very unusual mechanism of action. Ultimately, we hypothesized, based on the kind of DNA damage we found, [that] a particular enzyme that might be causing it. Ultimately, that was proven to be the case, which was very exciting.

S: What sort of cancer is it used to treat?

R: Oh, lots of them: leukemias, breast cancer, ____ cancer. There's a lot of cancers it's used for.

S: When you finished up there and started at Florida in 1978, did you mention already where else you had considered? You considered going back to North Carolina.

R: Yeah, those are the two primary places.

S: Why did Florida win out over North Carolina?

R: Well, it was a combination of things. Part of it was that North Carolina was in a little disarray. They never really had oncology there. They just hired a guy to be the head of oncology, and it was not really very well organized and still pretty controversial. Whereas in Florida, everybody was pretty fired up about getting it going. And it was Gainesville; it was sort of like home.

S: So, there's was a division of medical oncology when you started, or did you go in to start that?

R: Yes, there was [a division]. It had just begun. It had been formed by a guy name **Rory Wiener**, and he'd been there, I think, a year before I arrived. I think I was the first person he recruited, actually. It turned out one of the other clinical associates that I had done pediatric and medical oncology with also came down, who I'd introduced to Rory, and he came down with me. They converted the classroom on the fourth floor of the medical science building then, and one of my classrooms, as a student, they converted into two laboratories. So, I worked in that space in medical oncology. Over a period of two or three years, it was a series of conflicts between Rory and myself around directions and one thing or another, some of it was personalities, I think, in all fairness. I decided that I'd be better off being in the Pharmacology Department. **Al Neims** had become Chair of Pharmacology. He and I became friends and I ended up moving my laboratory into pharmacology. [I] was still seeing patients in medical oncology, but [I] was really more aligned with the Basic Science Department in some respects. I was very successful from a research standpoint in that environment. It was a good move.

S: Did you still have an appointment in medicine?

R: Yes, I continued to have an appointment in medicine [and] continued to be attending physician and to treat patients. In fact, I got a Clinical Teacher of the Year and a Hippocratic Award around that period. But I wasn't on a day-to-day [basis], always caught up in the politics of the clinical unit.

[End side A1]

[Beginning of A2 is recorded at extremely high speed but slows down to normal speed at 00.5]

S: What was your day like, then, and did it change when you went over more into pharmacology? It sounds like you were dividing the time between clinical practice, or I guess you didn't actually have a clinical practice at any point, or did you?

R: Oh yes, I had a clinical practice the whole time I was there. I had my own clinic practice and I attended on the in-patient service.

S: You did that, and that continued after the switch to pharmacology. You had a research lab and you were teaching as well. So, I guess those are the big three.

R: Without being particularly self-serving, I think it's fair to say I was what they used to call a triple threat. I had got teaching awards, I was pretty successful with my research, and I think I was a pretty good doctor.

S: Well, do you want to expand on any of those three, or all of them?

R: Let's talk about the teaching a little bit. I came back and, when I got into the Pharmacology Department, there was a fourth-year pharmacology course that had been around forever. Students do pharmacology before they do their third year, and then they come back in their fourth year and they do it again. It had always been really repeated, the basic science. Dr. Neims asked me to run that course, which I was pleased to do. I totally changed the direction of it to more of a therapeutics course rather than, what's the molecular mechanism of action of this drug? It turned more into, what do you do when a patient walks in the door with this problem? How do you choose the drug? How do you choose the dose? How do you make a decision to change it? It was a wildly popular course, and it resulted in several of the teaching awards that I got probably, if I was to be honest about it. I didn't teach the whole thing, but I ended up teaching a number of different parts of it. More than that, it gave me an opportunity to get to know students, which is something most faculty don't get to know. You don't get to know the students because you're not exposed to them for long, but I did. I was able to get to know them by name. For eight weeks or something the course ran and I was there every day. I'm very proud. As I said to somebody the other day, I don't put up my degrees, I don't put up papers I've written, [and] I don't put up gifts patients have given me, even though I have all those things. The only things I put on my wall are the teaching awards from the University of Florida. I'm very, very proud of those.

S: The Outstanding Clinical Science Teacher in 1983 was for bedside or award for teaching?

R: It was a combination. I think it was probably as much from the course as anything. It was the first year I think I'd taught the course, but it was a combination. I think I did pretty well on awards. I got not only the Clinical Science Award, but the Basic Science Teacher Award. I don't think many people do that. There's not that many people that are going to get both the Basic Science Teacher and a Clinical Teacher Award. I'm very proud of that. Then, I got the Hippocratic Award.

S: You got Teacher of the Year in 1985 and then the Hippocratic Award.

R: Right, and then the Hippocratic Award, which is really about the pinnacle, I think. I'm probably prouder of that than anything [else] I've done in my career if you want to know the truth. Then, in 1985 the graduating class asked me to give the commencement address. I think it was 1985, [but] it might have been 1987, actually.

S: 1985.

R: 1985, yeah, they asked me to give the commencement address, which I did. Oddly enough, because that was in May, the then-president, Marshall Criser, had just started this thing where the August commencement for the entire university, the address was to be given by a faculty member. Somebody had heard my commencement address and liked it, so they asked me to give the university commencement address, which I did that August. So, I went from giving what I thought was a pretty tough job, which was giving the Medical School Commencement Address, to now speaking to 8,000 people or something. I gave that one. Actually, the hardest commencement address I ever gave, the only other commencement, which was the hardest one I ever gave was about four years ago. I gave one at Oak Hall High School, which is where my son went to school, not for his class, but for another graduating class. That was probably the hardest one in some respects. The pressure was really on there. I was actually pretty proud of that.

S: Did you have to alter the one for the College of Medicine then to speak more broadly?

R: Oh yeah, I rewrote it. I rewrote it almost entirely.

S: What did you say and how did you decide what to say?

R: I can remember the Medical School one pretty well. I chose to focus on the notion of sensibility as something that physicians need. It's funny at the end, now that I think about just looping back there in earlier conversation. They were talking about another curriculum change at that point; it's like cycles in my life. I

was really pretty disturbed because I thought they were just tinkering [with the program], so towards the end of my commencement address, I made a comment that my impression was that the changes being envisioned in the curriculum were like rearranging deck chairs on the *Titanic* and that we needed to keep in mind that students learn a little of what we teach them, but they learn a great deal that we don't teach them. [I said that] it's a mistake to think that what they learn is only what we teach them; that's a small part of it. They were literally going back to a model that was sort of the antithesis of what I had been trying to do. It was really up the student to do it, mostly. Anyway, so that's what I talked about. The university one, honestly, I can tell you certain things that were in there because that was right when there was a famous experiment where rats were transfected with the human growth-hormone gene. They grew to be twice the size of normal rats. It was a very dramatic picture of it. I remember talking about that we had to think about science and manage technology and understand the implications of technology. I just remember it because the basketball coach at that time was Norm Sloan, and I made some comment in there that maybe Sloan would be interested in having players with that growth-hormone gene. We didn't have very many big people at that point.

S: What about research?

R: My research during that period was really focused on drug development, on understanding the mechanism of action and drugs around this particular enzyme that we had hypothesized and later were part of identifying. In the latter part of the 1980s, I became the head of a national cooperative drug discovery group, which we did with what was then **Smith, Klein, French,** SKF, and some people at Johns Hopkins and the University of Virginia. We had a five-year grant to come up with new drugs. We had chemists and biochemists and myself, and a variety of other people. That was a great era. We did some interesting things. A drug that's in use today, **Tocoteecan**, came out of that particular group.

S: Just to get some of the dates down, 1978 to 1981, you were assistant professor, and then it shows here in 1981, did you become Director of the Clinical Pharmacology Program at that point?

R: Yes, that was the title they gave me when I moved to the Pharmacology Department.

S: Was the division of medical oncology growing at this point? You were peripherally connected, I guess, but were they still building that?

R: Yes, they were expanding, right.

S: I'm sort of curious because we were talking earlier about how when you were in

medical school, Florida was still fairly young and small. At what point do you think it mature, or did it mature, I guess I could say? Obviously, it continued to grow. Did it sort of mature as a medical school?

R: That's an interesting question. I think, like many medical schools, it underwent phenomenal growth in the late 1970s and 1980s. The growth was almost entirely in the clinical department. It had the effect of making the hospital a much more exciting place to be and much more the focus of the public's view of us, and less so the Medical School. The clinical faculty had a lot of technologies at their disposal in the hospital, and that was where a lot of the excitement was. They became less and less likely to spend time with medical students, less and less likely to spend time in the research lab. That's true in many medical schools, but certainly in Florida that was a very big issue. I think it was during the 1980s that the school sort of became a bit more of what it is. It won't ever go back to that because, as it's grown, the research pieces have become bigger, but they're bigger as research pieces. They're not integrated, clinical education. I mean, you didn't walk out of your classroom like I used to walk out of the classroom with Dr. Oppelt and then walk down to the lab with him and then maybe walk down to the clinic with him or something like that. It's very different now. There are better parts to it and there's worse parts to it, but it's different. Any dean today struggles with, how do we get the students to have more contact with their faculty, even though we have many more faculty now than we had then? That's the period I think when the school sort of began to take off. Even though [each] class wasn't bigger, the school was bigger and a little less personal.

S: It seems like at medical schools, the research really funds a lot of the medical schools at this point, or at least the grant dollars.

R: Well, it's an interesting question. I don't know how much it does today. I know that there was a time at which it funded 35 [or] 40 percent. That number then dropped during the 1980s when clinical got much bigger, close to 50 percent of the whole. I know under Ken Berns the research enterprise has grown some, but I don't know where it is now. Still, I'm sure the clinical business brings in a lot of, probably 40 percent, of the budget in the School of Medicine. It's shocking.

S: You mention in your c.v. about the Director of the Drug Therapy Service, was this at Shands?

R: Yes, it was an interesting thing. It was just an experiment that was good in some ways. There was a thought that physicians who were very skilled in the use of medications could provide expertise, and, in my case, it was expertise outside of being an oncologist. So, I worked with some of the **PharmDs**

[students getting a doctorate in pharmacy] who were there for patients who were having difficulty with various kinds of medications. The one that I remember the best, and the one that I think I had the biggest impact on, was pain problems. It sort of fit with this whole palliative care thing that I ultimately have become very interested in. I think we really did have an impact; we also made a little money. We were able to bill for our services. It grew a little fund that I could use for other things, so it was worthwhile.

S: Is that continued?

R: No, I mean there are **PharmDs** running around, but I don't think anybody's doing that. That was just me and a couple **PharmDs**.

S: Was that something that you initiated and created?

R: Yes.

S: You went on, got tenure in 1983?

R: Whatever it says.

S: It looks like promotion to Associate Professor in Pharmacology and Medicine in 1983.

R: Right.

S: You talked about the big three, or that you're a triple threat in terms of research, clinical, and teaching, but then it does look like you started moving more into administration. What sort of propelled you into that?

R: I think partly I always imagined myself in some kind of leadership role. Sometime in the 1980s, which was in my thirties, I got into a conversation with **Will Deal,** who was the dean at the time. [We] talked about what it was like being a dean, and I sort of decided at that point that I was going to set my sights on becoming a dean one day. I thought it would be a while, I didn't know where it was going to be, but I thought that would be something that I would like to do. The way it actually happened was when I left in 1988 to be the Head of the Cancer Center at the University of Louisville it was a very complex job. It wasn't science necessarily, although there was recruitment and things like that. I had to run a business. I realized that if I was going to do this well, I was going to have to devout a fair amount of time to it. I could see that it was going to compromise other things. I was seeing fewer and fewer patients. I wasn't teaching at all hardly then. I still had my research lab. I had moved almost everybody in my lab up to Louisville. What happened was that I had been in Louisville for less

than a year when **Allen Neims** called me and said that, lo and behold, they had asked him to be dean and he really wanted me to come back and be his Executive Associate Dean. Well, there it was. It was the opportunity to be a dean, not only ahead of my schedule, but in my own _____. I had a chance to fix all the things that I was pretty sure I had identified as being wrong with it. So, I came back. The year at Louisville was very important, because it really convinced me that, if you're to do this well, you have to treat it as its own discipline and its own profession or calling, so to speak. I immediately gave up my research. I didn't try to renew the cooperative drug discovery group, and I turned in my research award. I had an NIH grant at that time that I had just gotten renewed. I basically sent them back the money, closed the lab, said, that's it, I can't do research and do this, and I threw myself into it. I view that time as like doing an internship again. I was doing a lot of stuff, but learned at least as much as I was doing. It prepared me very well for what I have done here.

S: Before we take off on talking more about that, why were you hired for this position at Louisville?

R: I had been at Florida for close to ten years at the time I started looking. Like a lot of faculty, I wanted to move up, I wanted to be Chief of Oncology. I wanted **Rory Wiener's** job. At one time, I thought it had been committed to me and then it didn't happen. This is such a recurring theme in academia, looking back on it. I had made the decision that I didn't want to stay under the circumstances that existed, so I decided to leave, so I started interviewing. It wasn't hard. I had good places making me offers, but Louisville was an opportunity. This is a bit of a recurring theme in my life, I think; Louisville was a place with enormous potential. [There was] very little there. There was a nice building. They had gotten a bunch of rich people together and raised $15 million and built this beautiful building, but there was hardly anything in it. I thought there's a lot of space, beautiful space, it's a nice town, it's not a great university, but it's a nice town, a lot of rich people could help you support it, I could do this. I just thought this is a big, messy challenge, I'll take this one on. I was glad I did. I learned some things.

[interrupted by phone call]

S: You were directing the James Brown Center. Was this something new that was starting up?

R: Yes, they had just raised the money and built the building. They hadn't really done much with it, so I went up there and started recruitment and started organizing. As I said, it was as much learning as anything. I got my lab set up. I got my grants renewed. Several things were becoming clear to me, one was

that the weight of a not-very-successful university was a bigger one than I had imagined.

S: You mean overcoming that?

R: Right. Secondly, there were some politics, as there are everywhere, but it wasn't the end of the world. I would have stayed. I was actually not that unhappy. I was frustrated at times, but I was not that unhappy there. It was at a time when I think, within a year or two, would have completed several key recruitments that would have changed it pretty dramatically. It's always that when you go to a really new job, that first year is difficult because they aren't your people, so to speak. It takes a while to develop the relationships that make it your people. I walked in, and for some people, I was the savior, and for other people, I was the devil. It was pretty interesting from that standpoint. It was a good year, and then when Allen called and then I felt a little guilty about it, but I can't say that I thought long and hard about it. I mean, I just made the decision and said, this is just too good to pass up; I would be stupid to miss this, and I'm out of here. So, after thirteen months, I was back in Gainesville working in the dean's office.

S: Did your family move with you to Louisville?

R: Yes, they went with me to Louisville and then with me back to Gainesville.

S: Were they happy to get back to Gainesville?

R: Oh, I don't know. I think my wife at the time was becoming happier in Louisville. That year in Louisville was very difficult for her, because her father was diagnosed with lung cancer, literally just before she moved up to Louisville, and died just as we were leaving Louisville. So in some respects, the associations with Louisville were not very positive ones. On the other hand, I think she did like Louisville and she didn't like change a lot. So, moving again was not something she really wanted to do, but we did. We found a nice house and we started to get settled in Gainesville again. It was very familiar and not very big.

S: [It's] easy to learn your way around. How large was your lab? This obviously is a period when you stopped doing research, but what sort of lab did you build?

R: You know, I think at its biggest, I probably had eight to ten people in it. I always had one or two oncology Fellows, a couple post-doctorates, some graduate students, three technicians, it was in that ranges. Mostly, they were people I liked. I think there was always a camaraderie about the lab. It's one of the fun things about having a lab. You have this little team of people you work with; it's fun. You have a small universe.

S: Would they do things together?

R: Yeah.

S: I guess I could ask about something that you have missed with research. You talk about wanting to go back, thinking about, palliative care. Is research sort of in the same bag, or is that something where, once you get out of it, it's harder to get started?

R: I don't. I mean, I can honestly say I never really wistfully thought about research, getting back into, partly because one of the reasons why it was easy to give it up was I was at that point where I was actually starting to change my research focus into a different area. If I was going to stay in research, I really needed to go do a sabbatical someplace; I needed to go away and retool.

S: Focus on that?

R: Yeah. The truth is, I wanted to run something. That's just who I am. I wanted to run something. I think I was born to run something. People have all kinds of things they think they were called to; I think that's what I was called to. I think, in some respects, this medical school and myself were on this course that no one could have predicted where it ended up, but I don't think there's any question that my experiences in my career prepared me as well as anyone could be prepared for this particular job. I think, no matter what else I do, and I'm sure I'll do some other things, this job in many respects was the apex. I look back at the University of Florida [and] I think it prepared me wonderfully. Hopefully, I made some contributions also, but it prepared me wonderfully for this job.

S: Well, I want to go back to Florida. I wanted you to talk some about the period between 1989 and 1994 when you were Executive Associate Dean.

R: Allen was very much a basic scientist. I had some clinical things, and my Louisville helped somewhat with that. Furthermore, if you know Allen...Have you done Allen?

S: I haven't done Allen, but they have interviewed him, and I know Allen.

R: Well, if you know Allen, you know he doesn't like controversy, he doesn't like confrontation, he's just a nice guy. He's kind of a warm and fuzzy guy. I can remember I came down there and he put in this expensive stereo system in his office. He listened to Enya all day long, and I thought, oh my God, and New Age music that sounded like tinkling glass and stuff. I was listening to [Bruce] Springsteen and the [Rolling] Stones, and he was listening to Enya. I mean,

he's just that kind of guy. He's a loveable guy, but he's like a rabbi in a way. So I ended up being the action guy. I ended up being, to some extent, the heavy.

S: It was like good cop, bad cop, and you were the [bad cop].

R: Absolutely, and it worked a lot and sometimes it was not very good. It was the way we were and I think we trusted each other, so it worked well. I think Allen knew he needed a bad cop, if you will. We'd known each other. Even though I didn't see the world the same way he did, the values were the same. I pushed him to do things he wouldn't have done otherwise, frankly. **Bob Watson** is a great example. **Bob Watson** is in the dean's office because I identified him as a person we needed to bring in and be head of education. That was just the way we operated. It worked very well with some exceptions. What happened was when I first got to the dean's office, I was involved in everything. I mean, I was like a kid in a candy store. I could be involved in surgery, I could be involved in education, I was learning finance, I was involved in clinical stuff. That whole thing with **Richard Rafty** and the creating multi-media materials...

[interruption from phone call]

R: This was the early 1990s and there was an emerging technology with CD-ROMs and digitized video and audio, so that it was obvious that much of what we were doing in medical education in a very labor-intensive way could be largely replaced with a technology-enabled platform. So, oddly enough, **Richard Rafty's** name came to us and we brought him down from the Harvard **Informatics** Course and interviewed him and were very pleased with the background he had as both a family practitioner and as a guy interested in Medical **Informatics**. We brought him down, we hired him, and set him up in a lab down there with a couple of texts and he worked with some of the faculty to produce teaching media that are now adopted nationally. In fact, there's a company out of Gainesville that had I think been very successful marketing the products that **Richard Rafty** authored in many respects. That was actually one of the most satisfying and innovative things I think we did. It's something that has stood the test of time in every respect.

This early period that I was describing of sort of kid in the candy store, being involved in all sorts of things, we set up a little genetics center and got involved in a general strategic plan. I, along with **Steve Sloatan** of Shands Hospital, did a strategic planning process for the Medical School that was actually, even in retrospect, I think very sophisticated and very useful in terms of shaping the direction of the school's investments. But, as these sometimes work out, there was a single phenomenon which ultimately shaped my direction for the next,

almost the rest, of the decade. The school, even prior to my coming back, had embarked on a plan for a new ambulatory care center and had determined that [they] needed to hire a CEO for that ambulatory care center. For whatever reason, and I can't remember exactly what all the reasons were, the decision was made that I would serve that role as Executive Associate Dean. That was a role that put me in great contact with hospital and hospital administrative staff as well as [it] required me to get much deeper into the health-care market place, which was just really starting to explode then. You remember it was 1992 when Clinton was elected. Health-care reform was a very big issue; managed care had really now fully penetrated the national consciousness, especially that of doctors. You were seeing a new level of competitiveness between physician groups. So, that really put me on a very high-profile, somewhat controversial, path that shaped my career in an important way. In looking at our facilities, [we] quickly made the decision that we were way too restrained or restricted by having to have our clinics within the four walls of the complex there on Archer Road. One of the early things I did, which was very controversial at the time, was to lease a large, vacated grocery store on Southwest 62nd, an old Norman's Grocery Store that we converted into a sports medicine center that's come to be known as Hampton Oaks. We put family practice over there and some orthopedic services, plus a large sports medicine center which we had. That was a wild success. It instantly doubled the volumes. It gave doctors, for the first time, a feeling of what it was like to practice in a very nice space. Most of the ambulatory space was in the skin of the health center, it was not terribly nice, having been thirty years old. We followed that with a series of storefront clinics for dermatology, general internal medicine, and a number of other areas there on Newberry Road. I'm blocking on the name of that site out there, but it's that complex right there before you get to the mall, on the right.

S: Oh, I know what you're talking about.

R: That gave us some very important capacity. It freed up some space within the health center for expansion of other health clinics, but it also got us out into the community, which had a couple of interesting effects. One is [that] we were now available to the community. Many community members would like to see a health center adopted, but they didn't want to go to the health center, for obvious reasons. So, we were now accessible to a broader segment of the population, which was very popular. We were also now encroaching on the territory of private-practice stuff, which became very controversial. I remember in that period of time, I also gave a talk to the Alachua County Medical Society describing trends in health-care and pointing out that hospital utilization was dropping, that it was very likely that one of the three major hospitals – Shands, North Florida, and Alachua General – would have to close in the coming years because of reduced utilization. They were of course, all three, functioning quite nicely now, so that wasn't the greatest prediction in the world. It got everybody

pretty stirred up. You can just imagine. It was that time. It was the time when people were extremely anxious about Shands taking over the community, extremely anxious about managed care, **AVMed** was a very threatening phenomenon at that time, and I think it's fair to say that, from that time on, I really was only identified with clinical activities, which is sort of unfortunate in some ways. I was an academic first and, of course, I'll return to that hopefully in my current role. That dominated the rest of my three years, the total of five years, in the dean's office with Allen.

Certainly a number of things of importance took place during that period, but I think from my standpoint, the seminal ones were the change in our approach to ambulatory care and taking a little more seriously the strategies behind that clinical business. Now, throughout all this, and literally long preceding my getting in the dean's office, there had been a rising tension between the docs of the faculty and the hospital. The hospital at that time was becoming very successful, in contrast to where it had been in the early 1980s when it was failing. **Homets** was the CEO and had a very financial view of things. I had a little problem sometimes with his style and I was, on behalf of the Medical School, fairly aggressive in advocating for the Medical School. The president, John Lombardi, was watching all of this and I think it's fair to say that John was not happy with some of the leadership issues in the hospital. [I think he] felt that the hospital had become far too independent of the university in many respects and that it needed to become more a part of the university, although no one wanted it to lose its separate not-for-profit status.

One day out of the clear-blue sky, and I was at that time being talked about for an important position at the University of South Florida, I got a call from John Lombardi that was sort of along the lines of the first shall be last and the last shall be first. Everybody who thought they were in charge really weren't going to be in charge and that he wanted to talk to me about reorganizing things, and out of that came the University of Florida Health System, which we commenced in 1994, at his behest. It was another, separate, not-for-profit corporation really intended to provide strategic leadership to the hospital and the practice plant. The thought being that over time, fee-for-service medicine was going to go away, everything would be capitated, and if all the capitation dollars floated through this new entity, it would become the dominant entity and the hospital and the practice plan would more or less collapse under this new entity. So, that was a fairly sharp infection point in my activities at the Medical School. If you want anything more about the time when I was in the dean's office, this would be the time to do it, otherwise we'll move on.

S: At one point you were talking about how you and Allen operated. You said it worked well, with some exceptions. I just wondered if you would elaborate on any of the exceptions.

R: Well, I would say that, without question, the most painful mistake I made...I made a lot of mistakes, as anybody does and certainly somebody who's, for the first time, carrying that level of responsibility and feels the extra responsibility of, if I didn't take an action, an action wasn't going to be taken. We had a chair of Radiation Oncology at the time, **Rod Million**, who was an international figure and somebody that I had been a personal friend with and had a great deal of respect for what he had accomplished there at the University of Florida. Shortly after we were in office, we had the faculty evaluate the chairs. We were both stunned, I think, to see the level of conflict that existed in Radiation Oncology. All of the faculty had been trained by **Dr. Million** and all of them had come to work for him, but there was an extreme level of unhappiness with him at that time. Rod was a pretty haughty guy in his own way, and I think over the year or two came to resent the dean's office interventions, came to resent almost everything we did. Allen and I had concluded that we really did need to make a change in that department, but again Allen was not a person to take action. So, we agreed that I would meet with Rod and inform him that we would really like for him to retire and, if not, we were prepared to take the necessary steps to remove him. It was a very ugly conversation. The reason I find it so painful in retrospect is, first of all, the number-two person should never do that, that's totally inappropriate. I shouldn't have stepped into that situation and Allen should never have allowed me to do that. When the deed was done, and I think Allen was actually out-of-town that day, but when he came back and Rod came to see him, it was not at all clear that Allen was totally supporting me on that. What ended up happening was that Rod remained in the position for another few months and ultimately just totally self-destructed and quite angrily. It was not a good example of leadership on either Allen or my part frankly. It's painful for me, not only because it was a procedural mistake, you make those and you learn from them, but it was also painful to me because Rod had been a friend and I had never wanted to be in that position with him. I was acting on behalf of school and doing what I thought was right, but it certainly alienated me from him and from his family, who I had known, including his daughter who was a graduate and had gone on to a career in radiation oncology. It was just one of those things I wish had never happened, but it did.

There was, I think over time, there were moments where, in my role as the person pushing Allen to do things, I would feel less than totally supported. If I were to sort of put myself in his shoes, I'm sure there were times he felt he'd been pushed further than he was prepared to go. It was just one of those things I think. I think, right around the time I moved out of the dean's office, that this School of Medicine started having real financial difficulties, and that was the beginning of what became I think the most painful moment of my entire career, ultimately. The School of Medicine began to have financial difficulties, and I think, in retrospect, it was very simple, there wasn't a single accounting of all

revenues and expenditures. We were literally having multiple people spending off the same accounts without ever looking at the total picture. It was a function of not having a strong financial officer in the Medical School. At the time, we did not have a strong financial officer. One consequence of that was we were spending against our savings account, our financial reserves, and they were dropping fairly rapidly. I remember, this was after I left the dean's office, but I was still certainly inner circle within the School of Medicine and very much involved. I remember one Saturday John Lombardi coming to my house here, sitting at that table right over there, because I wanted to talk to him about my concerns for the School of Medicine and the fact that I didn't think the financial situation was being taken seriously enough.

[End side A2]

R: To this day, I don't think anybody other than John and I knew that conversation took place. It gave John a different level of awareness of the issue and resulted in ultimately the presidential interventions in this. Just to continue that thread, I was at that time as the CEO of the University of Florida Health System, I was also Associate Vice President reporting to David Challoner. I sat in, if you will, sort of high-level discussions around the School of Medicine. I remember looking at the finances in a meeting one day and the discussion being, were we going to need to cut faculty salaries? The decision was made that we would probably need to cut faculty salaries by ten percent in order to break the problem down. In retrospect, it's kind of a joke, because I think the truth of the matter is, knowing what I know now, we hadn't even come close to adequately evaluating all the other options. I think we were just thinking that would get everybody's attention quicker than anything else. Well, it did get everybody's attention, and it was lighting a fuse on a keg of very, very dry, very, very potent gun powder because the faculty over time, I mean the unrest in medicine had led to anxiety on the part of the faculty. They were no longer feeling as protected and insular as they had in years past. So, there was a lot of anxiety anyway and then when word leaped out that we were bringing in a set of consultants from the outside and that there was a financial crisis, and that the faculty may have to take a salary cut, it led to a phenomenon I don't ever want to see again. It's just a lesson you will never forget in your whole life. There became almost a herd mentality, almost a riot kind of mentality among the faculty. There were conversations everywhere, anger everywhere, and it was anger at anybody that was in charge.

We brought these consultants in, and I will never forget, we had a meeting where we brought the consultants in to meet the general faculty. They were guys from out-of-town. They were from big cities, they dressed very, very well, a couple of them were a little poofy in their dress, a few too many bracelets and necklaces and things, and, oh my God, you could just feel the anger and the resentment

and the derision that the faculty were expressing towards these guys. It was a very ugly faculty meeting. This continued over a period of a year or so and I think it was probably 1996, in May/June [that] the faculty took it upon themselves with the tacit endorsement of the president to take on a vote essentially of no-confidence in every leader there was. There were six of us. It's a day you just don't forget, when you wake up and you sit at that table and read the *Gainesville Sun* and there is your picture above the fold, this may have well have been a D-Day. There was your picture along with five other people and some of the most derogatory comments that you've ever read about a person, right there on the front page, knowing that the next person to read that newspaper is going to be your kids. It was a moment I'll never forget. I don't think I'll ever get over it; I don't think I'll ever forget it. I learned a lot from it. I can't say I'm glad it happened, but I definitely learned a great deal by it. I think it's shaped a lot of management style today. In addition to the vote, they were given the opportunity to make comments and there was a compendium of all the comments. How adult human beings wrote some of the things that they wrote, I cannot understand. I mean, it was just nasty, personal, nasty comments about your family, your mother, I mean, just nastiness. It was just a barometer of how angry the faculty had gotten. The level of civility had fallen to an extraordinary low.

That resulted in ultimately Allen resigning and my recognition that if I was going to remain there, I was going to need to work pretty hard on my holes. That was a very difficult period, and a period in which I had to give real thought to whether to remain there or what my future there was. Frankly, the only thing that sustained me in that period, the *only* thing that sustained me in that period, was John Lombardi kept telling me, hang in there, he didn't see that I had done anything wrong, he felt this was getting tarred with a barbed brush that really didn't relate to me, and to wait it out and see what happens.

Meanwhile, in this role as Head of the University of Florida Health System I discovered a couple of things. The most important thing I discovered was, it didn't matter who appointed you and it didn't matter what your title was, you couldn't easily take a leadership role in planning, much less governance, if you didn't have the capital. All the capital was in the hospital and the practice plan; that's where all the money was, and I didn't control any of that. So, any decision we made as part of this new entity ultimately had to get approved by two of the boards. It clearly was off to a very slow start. We did accomplish some things. We certainly developed, I think, a pretty good managed-care strategy and continued incorporating positions in the community into our network and looking at where we ought to practice.

I'm going to digress from one second. When we created the clinics out on Newberry Road, the name of which is escaping me at the moment, I remember

one day sitting in my office. It's one of these things you don't ever forget. I got a call from Orvin Jenkins who was the Chief of Staff, I think, at North Florida at the time, somebody I had known from medical school actually. He called me up to give me a bunch a grief about the fact that we were out there. I said, gee, we were just going where people wanted to see us and trying to serve our constituency, and he said, well, I noticed you planted your clinic in the very nice part of town, you didn't plant it on the east side of town. I said, well, as a matter of fact, we were going to do just that. Of course, I had never thought about it before, but the more I thought about it, I thought, you know what, it's not a bad idea, let's look at it. So we started doing some market research on it. There was a sense that I had, from a mission standpoint, that we were obliged to do that. I've always sort of been the liberal Democrat of the crowd in a world of Republicans. I thought it was part of our mission and John was very supportive of it.

We started doing some market research, and what you frequently find in the poorer sections of town is, yeah, you've got a lot of folks that don't have insurance, but you can take care of them much less expensively there than if you wait until they get to the hospital. Secondly, most of the people in that area are actually working people. They are the working poor and they do have insurance, because in the city of Gainesville, they tend to work for the state or the city and therefore they had insurance. You know what, if you have insurance, it doesn't matter what your annual gross income is. So, we began planning for what became the Eastside Clinic, which, when it opened, was one of the proudest days of my life. It all came from that conversation. It's something to this day that I feel like is a legacy of my leadership that I'm very, very proud of.

So, we'll go back to the Health System business. The direction of the Health System changed materially one day when I was invited to dinner with a representative of the **AvMed**. [He] was a merger-and-acquisitions specialist, his name I'm blocking on, from out-of-town and he invited me to dinner and basically made the proposition that **AvMed** wished to sell its hospitals and wanted to know if Shands were interested, if the University of Florida were interested in acquiring its six hospitals. [He said] that they would probably be making an offer to North Florida (or Columbia Health System at the time) as well. But [he said] that certainly there were a number of people, given their not-for-profit orientation, that would prefer to see it as part of the emerging University of Florida Health System. Now, that was a pretty big deal and what was important about it was they had come to me, not to Shands itself and **Paul Metts,** who was the CEO of Shands. I felt like I could speak for the president, which had some significance, but of course I could not speak for the Board of Shands, which is where all the money was. We had embarked on a process of evaluating the acquisition and it became quickly clear that it made sense to acquire the hospitals, but acquire them as part of the Shands Corporation, not this Health System Corporation.

We didn't know anything about running hospitals, it belonged in a hospital corporation. Although I led that whole project to acquire the assets; I mean, I'm very proud of that accomplishment, I think it was a good acquisition by and large. It pointed out to me, and I think to John, that the structure we had in place was really not going to be a viable structure.

[interruption from phone ringing]

R: So, it pointed out that this University of Florida Health System Structure would always be the tail wagging the dog. In many ways, it had increased the level of conflict people were experiencing and observing because we were now pitting this Health System entity, which was the creature of the president, really pretty directly against the hospital CEO. I think the College of Medicine, in its own way, sort of went back-and-forth to how they wanted it to go. By the time we finished the **AvMed** acquisition, I sat down with John and said, this structure is not going to work. [I said,] what we need to do is create one entity, one corporate entity and pull everything under that. I recognize that only one person can be in charge of that and there will be many stake-holders in that conversation and you'll just need to do a search and decide who you want.

I think it's fair to say that, right to the end, I think John would have preferred that I end up with that role. We did a national search, they hired a search firm, they did a national search, it was the Shands Board, in essence, that was doing it, because it was decided that everything would roll under the Shands Corporation. So, the Shands Board was the group that was making the determination. I think, in a very simplistic sense, what happened was a number of the board members had a lot of loyalty to **Paul Metts**, [and] Paul very much wanted the job. There were a certain number of board members that were very supportive of me, probably mostly because of the president, quite honestly, and then there were some board members who frankly didn't know what to do. In the final analysis, what they ended up doing was hiring a person from the outside. **Dick Gainter** came in as the peacemaker, so to speak. That was painful, painful for a lot of reasons. There were some personal issues. At the same time that all this was going on, it was becoming increasingly clear to me that, if I didn't get this job, I wasn't going to remain in Gainesville, and I was not at all clear that my wife and children were going to end up going with me. So, I had a lot of stuff going on at once.

Anyway, I made a good-faith effort to work with the new CEO. I focused a lot of my efforts on putting together the Shands Jacksonville deal. Paul Metts and I were the initial proponents of it, oddly enough. Paul left and I carried the ball and took it a pretty long ways before I formally left in September, August of 1998. I turned the leadership of the project over to other people [and] it was ultimately consummated, I think, about a year later. It was a very complicated deal and a

lot of controversy. It was like a lot of things. Eastside is another example. The concept that we laid out made a lot of sense, [but] once it got done, once the deal got done, the people responsible for executing chose to take a different path. So, Shands Jacksonville made a lot of sense if you were willing to take two hospitals and truly consolidate them into one. Once they actually owned it, they chose to take a more politically timid path and tried to keep both entities running. Consequently, they never really got it under control. It's not at all clear where its future is. It's too bad, because it's a very important initiative for the university. I suspect it will ultimately work out, but it's not been quite as successful as I had hoped.

S: It was not a smooth transition or anything like that?

R: No, very difficult. They have a big turnover now. One of the things I learned in all this was being a visionary really wasn't enough. I think it's fair to say that I was a pretty visionary person. I think that, if you ask people who remember me, what do you remember of him, they will probably tell you a number of things, some of which wouldn't be altogether positive. [They might say I was] outspoken and action-oriented, but I think what they would tell you is that I was a visionary person. I think sometimes my vision got ahead of reality. You have to meter your vision to the context, to the culture of the organization you're in. If they're not willing to jump across a chasm, then whatever is on the other side is probably not attainable anyway, and it's just as well not to take a half- measure in that jump. I guess it's fair to say that my career at the University of Florida ended painfully, and painfully from a professional level and painfully from a personal level. I'm proud of a lot of things I did...

[interrupted by phone ringing]

R: Where were we?

S: Leaving Florida was painful, professionally and personally.

R: Remember, I spent most of my adult life in Gainesville. I went to high school, college, medical school, was a faculty member, [and] was in the dean's office. I had ascended and, I can't remember if I told you this earlier, but I remember distinctly and I told enough people who remember that I said this, when I was literally a medical student, I can remember saying, one day, I'm going to run this place. I wanted desperately to run it. I think I fell one spot short, but I had an influence and I got some things done and I certainly learned a great deal. It was a very painful time in my life. I ended up within a two-year period, if you will, losing my job, losing my marriage, and losing my father. That's a tester for anybody. Plus, I had to move, because I wasn't willing to just go back to the faculty, I didn't want to go into private-practice, and I think I sort of felt it was

important for me to move on and do something else.

S: Just a question, was that vote of no-confidence in 1994?

R: 1994 no, it would have been 1996.

S: [The] faculty then sort of settled down after that? What was the level of tension?

R: I think the faculty, first of all, they didn't get their salaries cut and, with the consultant's help and a lot of effort, the school's finances turned around. Allen resigned and **Jerry Modell** and **Ted Coplan** became the interim deans, with **Jerry Modell** as the interim executive associate on campus. The school's finances turned around very quickly, and I think the faculty settled down with that. They had gotten some red blood, salaries were saved, and I think they began to calm down. What was gratifying to me was, I mean I worked pretty hard, sort of campaigning, if you will, for the faculty support for the CEO job. Oddly enough, a lot of the people who had really been virulent earlier came around and were supportive, but it didn't matter, they weren't voting. It was nice, but it didn't change anything.

S: I was also curious about research dollars and the whole sort of research end of things. You had talked about the hospital and the money coming out of there, what about the Medical School and research at the time?

R: As Allen and I started [our] tenure, we started a new academic research building. We should have seen a substantial jump in research funding that I don't think we ever really saw, for a variety of reasons. There was a steady increase. A very important thing that happened during Allen's tenure was the decision to compete for the grant that ultimately led to the Brain Institute. I think Allen was quite visionary in that, and of course Bill Luttge did a lot of good things with that, but that was a very, very big deal. I didn't have much to do with it, I'm sorry to say, I would love to take some credit for that, but I actually deserve no credit whatsoever for it. It was just a wonderful thing to have happen.

S: Let's move back then. You left Florida in 1998?

R: Yeah, I joined a consulting firm in Boston. I had become friends with a lawyer who was part of this consulting. This was a consulting firm that was really part of a much larger law firm. So, I got an apartment in downtown Boston and moved up there. [I] lived there during the week and came home on the weekends. Very early on, actually, truth-be- known, it was before I even accepted that job, I did a consulting gig at this [Drexel] medical school while it was in bankruptcy. I ended up getting to know many of the chairs and some of the people around here. My name circulated and they would call me periodically

wanting to know, when the dust settled, would I be willing to come in as dean. I think I had a pretty good skill-set match, and I really didn't want to be dean. I was so embittered, frankly, by the political events of the last two or three years that I wanted nothing whatsoever to do with academic medicine or not-for-profit health-care or anything else. I was really ready to see the world and see what else was out there for me. Drexel took over. The school came out of bankruptcy, Drexel assumed responsibility on November 11, 1998, and about a week or two later the President of Drexel, **Popodokis**, had heard about me and came up to Boston to spend some time talking. He asked me to be dean, and I said no. I said, I could come down and be your consultant, though. [I could come down] a couple days a week and help you get this thing going. He agreed to that. I actually came down and tried very hard to help them find a dean. We had a candidate from the University of North Carolina that people seemed to be converging around. I worked very hard to help them hire that person, thinking I would get a good consulting gig out of it, and that would be the best of both worlds. Well, you had to be a real risk-taker to take that job and this guy turns out wasn't, so we fiddled around between December and February with this guy and finally it fell through. Frankly, I think if we hadn't appointed a dean pretty quickly, the school was not going to continue. So, they asked me again and I said, yes, I would serve as interim dean for six months and then they could find a dean. I mean, I was already there two days a week, but my three days away, I was spending on their issue, so I really wasn't getting much else done. I was starting to really like the place, so I agreed to take it on and I became acting dean right around the March 1, 1999. In August, my six months was up, [and,] at that point, I was very happy. I was very engaged. I had made the decision when I left the University of Florida, based on the events that had taken place, that I never ever wanted to work someplace I wasn't both needed and wanted, and if there was ever a place that needed and wanted somebody, this was it. It was just a very good feeling. You didn't deal with a lot of petty stuff. People just were all trying to get their work done so that we could save this place. I think I had changed a lot. I got beat up pretty bad and I think I learned some things out of it.

So, I took this on and we went from losing around $50 million on an annual basis the first year; it was only a seven-month year. Then the next year, because we didn't really have much time to change anything, we lost about $40 million, $44 million, I think. The stuff we were doing finally took hold and we lost $10 million the next year and then broke even. We're now making money. It was a very positive sequence of events. We have a lot of new department chairs and a very good feeling in the school. I think people are very enthusiastic about the school. I like to tell people, you just heard me there, I tell people this is largely a new school. This is the oldest new school in the world, and we're very proud of what we do. Our students do very well. We're very focused on students, much more so than the University of Florida ever was, at least not since a long time

ago. All medical schools have sort of lost sight of students. We're very focused on students and it shows. I think it's a school with a bright future.

S: Would you give some background on what led to the bankruptcy in the first place?

R: It was a very peculiar story. Allegheny General Hospital in Pittsburgh was a pretty academic community hospital and was phenomenally profitable. They decided they really needed their own medical school, for whatever reason. They found one in Philadelphia called Medical College of Pennsylvania, which had formerly been Woman's Medical College. MCP was like many Philadelphia medical schools, a medical school and a hospital in one corporation. [There was] no university, just a medical school and a hospital. So, Allegheny came in, MCP was financially unstable at that point, and Allegheny came in and bought the medical school and hospital and began putting money into it. Later, [Allegheny] bought Hahnemann Medical College and its hospital. Then, it merged the two medical schools into one medical school, which they called MCP Hahnemann. The merger was a painful one. They were culturally very distinct places and didn't really like each other. It wasn't a great merger, I would have to say, a lot of resentment. Then, Allegheny proceeded to buy a number of other hospitals and acquire a lot of primary-care practices, which was *en vogue* at the time. They borrowed a lot of money. A lot of the problem was, they just didn't know how to count their money; they had very poor business systems. They got very overextended and they ultimately ran out of cash to run the place. There were horror stories in the newspaper about people undergoing surgery and the lights going out and stuff like that. I don't know how much of it is true, but it was pretty devastating public relations, I can tell you that. Finally, in July of 1998, they just ran out of money and went bankrupt, you know Chapter Eleven bankruptcy. It was the largest health-care bankruptcy in history, and I think the only medical school to come out of bankruptcy. We're now the largest private medical school by enrollment and I think very sound. We're known as Drexel University College of Medicine, and we dropped all that other stuff and [have] sort of a fresh start. We're part of Drexel University, which is a very up-and-coming university in Philadelphia, and we're starting to really shine, I think

S: Did Drexel have its own medical school at the time?

R: No.

S: What about sort of the physical [facilities], I mean, MCP had its own facilities, as did Hahnemann, what's happened with that?

R: Well, one of the things that Allegheny had done that was very good is they bought a Lutheran publishing house, which was near the MCP hospital, it's a

beautiful building, and they put about $35 million into it and it's now an education and research facilities. It's where the students spend their first two years, and there's a number of research labs there as well. It's just a spectacular facility. It's got everything you could want for a medical student, and the medical students just love it there. It's like their home. Then, when they do clinical things, they go to a number of different places. They still go to the MCP hospital, they go to Hahnemann hospital, they go to St. Christopher's for children's hospital, and many of them go to Allegheny General, which is still one of our major campuses in Pittsburgh. We have a number of other sites that they go to, much like at the University of Florida, we sent our students to the VA and to Jacksonville. We have many more students and we have a much broader array of affiliate sites, frankly.

S: How many students do you have?

R: We're entering 250 per class.

S: What did you do to turn things around? What were some of the specific things that you did?

R: Well, the first thing, remember the leader of an organization is ultimately the chief culture officer among everything else, so a lot of what I did was establish a culture of, we're going to manage our resources prudently and we're not going to tolerate people who don't. So, we developed much better accounting systems. The place had a history of creating budgets about every three months. We said, you create one budget and you've got to make your budget. I opened the books. It had been very secretive, none of the faculty ever knew what was going on. No one was entitled to know how things worked or how money flowed or what the profitability of anything was. I opened the books. I said, anything but personal salaries are, as far as I'm concerned, open to everybody here. I think that was very well-received. To this day, that's very well-received. I said, there were a lot of suspicion of the department chairs by the faculty. I said, basically the department chairs are going to run the place, they're going to run their departments, they're going to be empowered to run their departments, but they're going to be accountable.

To make my point, in the first two months, I fired two of them, because they weren't doing their job. Actually, I've now fired six since I've been there. [I feel it's] something more deans need to do. These aren't lifetime appointments, you either perform or you get out. If you're a devotee of Spurrier [Steve Spurrier, former UF football coach], you know, if you don't perform, you get pulled. That's kind of the way I feel about it; you're got to perform. Some other things, I told you we created better financial systems, and then we began cutting things that weren't core to our mission. If it wasn't required to teach medical students, it

was at risk. We cut a lot of expenses, we improved the billing system to grow revenues, and gradually, over time, the clinical business built back up, the research business grew, and we came out of it.

S: I guess both of these schools are fairly old. I'm trying to remember, obviously Hahnemann would have been [established] about mid-nineteenth-century?

R: Yeah, both of them. Hahnemann was [established] 1848 and Woman's Medical College was two years later.

S: What sort of alumni support did you receive?

R: The alumni are all over the place. There's alumni that are steadfast and have been supportive right through it all. There are alumni who were angry that the name. There are still alumni from the old Woman's Medical College that are angry that it became co-ed and its name changed. There are alumni on both sides that were angry that the merger took place, because these two schools did not like each other at all. There was a lot of anger about Allegheny for two reasons, one is because they obviously drove their medical school to the bankruptcy, but also because...

[interruption from door bell]

R: During the Allegheny era, when the finances weren't going well and they were running out of money to run the hospitals, they raided the endowments and took money out of the endowments. So, many alumni felt that gifts they had made had been squandered. The leadership of Allegheny had done some pretty sleazy things. [Some people had] cashed out their own retirement and that sort of thing. There was a lot of anger about Allegheny and then suspicion about Drexel and [the attitude of,] we'll wait and see. Finally, we changed the name. There were some of them who never forgave us for that, even now. I would say that, on the balance, what I'm sensing is that, with the merger with Drexel**,** people feel like the medical school is going to survive. People sense it has a brighter future than it's had in a very, very long time. I'm starting to sense the alumni coming back. We'll never get some of them back, but I think to the extent that we can make them proud, they're going to come back.

S: I guess, certainly with the focus on students, too, that's likely to interest them and get to at least some of the loyalty. I guess I'll ask you to maybe sum up, in a more general sense, not just in terms of Florida or Philadelphia, your sense of where, not quite like the university and everything, but where academic medicine in terms of managed-care, hospitals, education, research, almost the whole nine yards, where that is headed.

R: Well, I think a lot of people would like to know where it's headed. I think it's gotten very large and complex. Remember, both the research enterprise and the clinical enterprise are highly responsive to the markets they live in. So, when the NIH doubled its funding over the last five years, the research enterprises of many of these medical schools have gone crazy. I mean, the amount of construction, even at the University of Florida, is a good example, is beyond any of us what we imagined. It's made possible by the new level of NIH funding. The clinical business grew first back in the 1970s in response to people getting paid for taking care of Medicare patients, finally. Then, hospitals became very successful and the practice plans became very successful and they expanded. They expanded because they could expand. What got left out of all that to some extent was the students. They got, I think, a little marginalized in all of that. But the expansion occurred without a lot of accountability. Finally, as these operations have become more complex, societies have begun to create a different level of accountability, the managed-care companies acting on behalf of the employers, and the government, to some extent, are telling medical schools, we're not going to pay for research through clinical-care dollars. You'll get paid to do clinical care, but you're not going to make enough that you can use it to pay for research. Furthermore, we're going to have a million rules for you to follow, so that you have to do it the way that we want you to do it. Some of [them] are very good rules and some are not, but it's a much more regulated structure than it used to be and there is a much higher level of accountability.

On the research side is exactly the same phenomenon. We have now huge amounts of money going in, but much more regulation. Whether its human subject research or laboratory safety, there's a much higher level of regulation. The support of research is great, but it's not going to pay for clinical stuff and it's not going to make schools rich necessarily. Salary support is good, but it doesn't come close to supporting. I think the most they pay for a clinical faculty member is like $150,000, and a lot of faculty make a lot more than $150,000, so it's only partial subsidy. Then, on the other side is the education structure. It's a little different for state and private schools. We're a private school at Drexel. Our students are paying $32,000 a year. They're walking out with over $200,000 in debt when they leave. I don't think that can go much further. I just think there's a limit to how far you can go in terms of putting students in that position. So, I have great concern about where we're going with that. I think we're going to end up killing the goose that laid the golden egg, because when you have students graduating with $200,000 worth of debt, they want to go into something [so that] they can pay it back quickly. They may or may not be what society most needs. What I see happening is that the three missions which had been so intertwined, are sort of captured in a folklorish way by the notion of the triple threat, the faculty member who does all three equally well. I think people are beginning to recognize, and you hear a lot of people saying, there's no such thing as a triple threat anymore. Well, that's not really true. There are triple

threats out there, but it's getting increasingly difficult to be a triple threat, just because of the time and resources required to be successful in each of the three missions, and [due to] the level of public accountability for each of the three missions. So, I think the management complexity of these organizations is growing. I probably say that, to some extent, because I think that plays into my strength, but I think that's absolutely correct. I think it's going to be very hard to run these places without having pretty sophisticated management skills, no matter how you come by them.

S: Clearly, you acquired them on-the-job. Is there a role for some sort of management training?

R: Oh yeah, I push all the chairs that I hire to take management courses. Our chairman of surgery is taking an executive MBA course right now. I don't necessarily think you need an MBA, but I think some management training is helpful, absolutely. If nothing else, it forces you to take the time to examine the basic principles of management and understand that there really is something to it. Most doctors think they can do anything. So, there's actually a body of knowledge and sort of a way of doing things. It's very different that the practice of medicine. That's management, and then there's the issue of leadership. Leadership is very different than management. Many times, academic medicine, academic health centers, put people in leadership positions for the wrong reasons. They've been accomplished academicians or they're nice guys, but leadership is more than those two things.

S: Sure, you have to be able to deal with confrontations among other things.

[End side B3]

R: I said leaders have to have a vision, but they also have to surround themselves with strong people that share, not only their vision, but the ability to execute, whether it be their immediate management team or whether it be the senior leadership of the school, namely the chairs.

[interruption by phone call]

S: So, you were talking about chairs.

R: Chairs are the most important level of leadership in the school, because the faculty, who are really, if you will, the means of production of the school, believe they are there to work for the chairs; they don't come there to work for the dean, they come there to work for the chairs. So, the chairs are critical to the success of the school. The departmental chair position has had great demands placed on it in the last decade or two that didn't used to be there. I think many people

who take those positions don't have a real understanding of what the expectations are going to end up being. Some of them just don't make it. Oddly enough, my observation is that the ones who flame out most dramatically don't flame out because they're not smart people, they flame out because they don't have emotional intelligence. They don't have a particularly good self-awareness, [and] they are not particularly good at understanding what is going on between them and others in terms of the interactions and how they're perceived by others or how to manage the interaction. It's really fundamental stuff and it's very hard to teach. I think you can refine it, but I'm stunned by how obtuse some people are to these very, very basic things, and, as a result, you have a mix. The dean's job is to put the best team on the field. The most important thing he does is the appointment of chairs and sending a message. The chairs cannot take these jobs with a notion that they're lifetime appointments.

S: I think I have one more question, and that had to do with sometime toward the beginning of the interview, when you were talking about issues of death and dying and dealing with that as a physician. I think you said something about how you wouldn't mind getting back into that. I'm just sort of wondering what you see as your own trajectory?

R: It's a good question, because I don't really know the answer to it. I love what I do. One of the interesting things, which is sort of a change for me is, I don't really want to go any higher. I'm not terribly interested in being a university president. I don't even want to be a vice-president for health-care anymore. I like hands-on, I like what I do. I feel like what I do means something. When I look at the students at commencement, it's a very big deal for me. It gives my life some meaning. I certainly could see myself doing it someplace else. I think I probably have got conceivably one more move in me, although I could see myself staying there. I always thought I would get it through the merger and then leave, but to be honest with you, I think the future is bright enough that I think I can build this into a really good medical school and five years from now be unbelievably proud of what we've done. That's what I'm now thinking I may do. If there's one thing I learned at the University of Florida, it's that you can't count on these things. Sitting on top is an easy mark. Most deans end up going out with a few bullets in their back. I don't necessarily expect to keep this job forever, you make decisions and you make a few penalties here and there. If that's the case, I think I got a lot of satisfaction from practicing medicine, and I could go back to oncology or maybe go back to the hospice work, but I don't really know. I sort of go back and forth about.

S: Is there anything else that you want to add, you think, to wrap up?

R: No. Fire Ron Zook [UF football coach who succeeded Stever Spurrier]. If you

could pass that message on...

S: [Laughing] Okay, well, that concludes the interview with Warren Ross.

[End of interview]