

**Gregory Hart, M.H.A.**  
Narrator

**Dominique A. Tobbell, Ph.D.**  
Interviewer

**ACADEMIC HEALTH CENTER  
ORAL HISTORY PROJECT**

**UNIVERSITY OF MINNESOTA**

## **ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT**

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

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

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

## **Biographical Sketch**

Gregory Hart was born and raised in St. Paul Minnesota. He earned a Bachelor of Arts in Business Administration from the University of Minnesota in 1973 and went on to earn a Master's degree in Hospital and Healthcare Administration from the University's School of Public Health in 1976. As part of earning his MHA, Mr. Hart completed a residency program at University Hospitals and Clinics and was hired to a permanent position. He became Director of Operations at the Hospital in 1982. In 1992, Mr. Hart became General Director University Hospitals and Clinics, and in 1993, he was named President of the University of Minnesota Health System. He resigned from the position in 1995, but served as consultant for the Hospital's sale to Fairview. Mr. Hart then joined LarsonAllen as a healthcare consultant.

## **Interview Abstract**

Gregory Hart begins his interview with a brief overview of his early life and education, with a particular emphasis on his time in the MHA program and his residency at University Hospitals and Clinics. He discusses the competition around the patient care dollar and the renewed emphasis on patients in the 1960s and 1970s as well as the creation of the Hospital's Board of Governors at the University. He then reflects on the emergence of Health Maintenance Organizations (HMOs), his work on InterStudy, the organization that developed the HMO concept, and changes the University experienced as a result of HMOs. He then discusses the following: technological change in the Hospital; cost controls; prospective payment and diagnosis-related groups (DRGs); regional health planning; University Hospital's relationship with area hospitals; town/gown relations; long range planning for Academic Health Center (AHC) renewal; labor issues and nursing shortages; comparative work for hospitals and gender equity; the organization of the University of Minnesota Clinical Associates; the emergence of HIV/AIDS; the leadership styles of General Directors of the Hospital and work with the legislature; Lyle French as the Senior Vice President for the AHC; the impact of the ALG scandal; the creation of the University of Minnesota Health System; the Hospital's mission; and the Hospital's sale to Fairview. He concludes by reflecting on the collaborative environment at the University and the relationships between the different schools within the AHC and the Hospital.

**Interview with Gregory W. Hart**

**Interviewed by Dominique Tobbell, Oral Historian**

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

**Interviewed at the LarsonAllen [LLP] Office in Minneapolis, Minnesota**

**Interviewed on February 9, 2012**

Gregory Hart - GH

Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Gregory Hart. It's February 9, 2012, and we're at the offices of Larsen Allen in downtown Minneapolis.

Thank you for speaking with me today.

Can you start with telling me where you were born and raised and about your educational background?

GH: I was born in Saint Paul, Minnesota. I attended North Saint Paul High School and did my undergraduate and graduate work at the University of Minnesota. I did my bachelor's degree in business and graduate school was in the University of Minnesota, School of Public Health, the MHA [Master of Health Administration] Program, Class of 1976, the best class ever.

DT: [laughter] Is that an objective evaluation?

GH: Absolutely.

DT: What led you to pursue a career in hospital and healthcare administration?

GH: When I was in what was then called the Business School, it was back in the 1960s and early 1970s, going the classic for-profit business route wasn't the politically correct thing to do in those days. So I ended up looking at non-profit type organizations and found my way into hospitals and healthcare, actually, by three part-time jobs. At one, I was the TV man at Saint Mary's Hospital, which, back in those days, meant you collected

two dollars a day from every patient who wanted a television. This was in 1970. I also was a research assistant for an organization called InterStudy, which was the organization that sort of spawned the original concept of health maintenance organizations [HMO] with Paul Ellwood and Rich Burke. And, then, before graduate school I worked at Methodist Hospital in Saint Louis Park [Minnesota] with another University of Minnesota alum [alumnus], I believe the second class of the MHA Program, a fellow named Earl Dresser, who was sort of my original mentor.

DT: What were you doing at Methodist? What was your responsibility?

GH: At Methodist, I was the nursing staffing coordinator.

DT: And what kind of responsibilities did you have there?

GH: That meant my job was to sort of plan long range for nursing staffing in the hospital and, then, on a monthly basis, schedule all the nurses and, then, on a daily basis, allocate the specific units that each of the nurses was going to work on.

DT: I was taken aback by that's what you did, because I've always assumed that was a position held by a nurse, but not.

[chuckles]

GH: My direct supervisor was the director of nursing, so I could call on her when needed.

DT: Okay, that makes sense.

What were your experiences like as a student in the MHA Program?

GH: Those were life-changing experiences. That would be the short answer. I think like a lot of graduates of our program, I remain very committed to it and have taught as a volunteer faculty member for however many years since then, including just as recently as last week. The bonds that I had the good fortune of making with many of my classmates have been lifelong and career-long bonds and they're still probably a dozen people I'm in touch with on a regular basis from the days in the program.

DT: Yes, I've interviewed several faculty from that program and from the School of Public Health and everyone says what an amazing alumni the MHA has.

GH: Yes. Yes. Yes.

DT: Were there any notable faculty that stood out to you?

GH: Well, the director of the program and that was Bright Dornblaser. He taught a class called Problem Solving, which I now proudly teach, as well, along with another professor

in the program named Sandy [Sandra] Potthoff. Everybody from those days, and many years beyond, remembers Vernon Weckwerth as their statistics and quantitative methods professor. We still, to this day, talk about wing flaps and his version of statistics, his vocabulary of statistics. We had a finance professor, a fellow named Dick [Richard] Oszustowicz, who was not a fulltime faculty member but who just did a wonderful job of getting us all well grounded in finance. Ted [Theodor] Litman's a wonderful guy and a great mentor to many students. I could go on from there, but those are the ones that come to mind.

DT: What do you think explains the tight-knit community that you have among your classmates? What explains that? It's not typical for graduate programs.

GH: No, it's not; it's really not. I think it probably goes back to the founder of the program, James Hamilton, and a fairly tight, small class, a group of students. You experience the program together, unlike most programs where most of your class work is with many different combinations of students. The MHA Program is a pretty defined curriculum. It was even more then than it is now today. Then, I think the culture that was built from those very early years. All of us have been taught that we owe something back, so we do that through our mentoring of students or contributions to the program or volunteer teaching time or whatever the case may be.

DT: I've been impressed by how many people say it's the alumni situation, that the alumni are really important.

GH: Yes. I was honored to serve as president of our Alumni Association a few years back, as well. A lot of people volunteer their time through the Association still.

DT: I'm actually curious... I know the MHA Program moved for a short time from the School of Public Health...

GH: Yes.

DT: ...to Carlson [School of Management]. Were you involved or at least...?

GH: I was. I was involved in both ends of that. I was less so on the front end, the move to the Carlson School. George Johnson was the program director then and I was still at the University Hospital. I think I was the CEO [chief executive officer] of the hospital at that point and an active alum and volunteer, so I spent a fair amount of time with George thinking that change through. I was certainly supportive of it. Unfortunately, it didn't work out the way we had hoped. I was *very* involved in a very contentious process of the program moving from the Carlson School back to its home in the School of Public Health.

DT: What prompted the move to Carlson?

GH: What prompted the move to Carlson was a sense that healthcare was becoming more of a business and that our students getting exposed to the faculty across the Carlson School in finance, in marketing, in strategy would benefit the students. It didn't work out that way. In fact, our students, I think, found themselves feeling like they were in foreign territory when it came to some of those other classes. We didn't feel the support of the dean's office. In fact, if anything, I think he viewed the MHA Program as a treasure chest to be raided for other purposes. So the alumni got together and along with the faculty leadership—although, not all the faculty agreed—said, “We really ought to head back to the School of Public Health.” I'm glad we did.

DT: I don't know about other institutions where hospital and healthcare administration is within the structure of the university. I think the move back and forth from Carlson points up to that kind of tension in, what is hospital administration and where does it best fit?

GH: Yes. My view is that it really does belong as part of an academic health center, and in some cases, a small number of cases I think, in the medical school...I think better in a school of public health. But, also, the ability to reach across the academic units of the Academic Health Center [AHC] is important for our students and I think for the other students, as well.

DT: As part of your master's, you served as the resident at University Hospital?

GH: Well, today, the program is curriculum structured, so it's a fulltime, two-year curriculum in class, and, then, ninety-five percent of the students do what we now call a fellowship after actually getting their degree. Back then, it was one year in class on campus and, then, one year in what we then called residency. Upon completion of those two years, you received a degree. So I did my second year of the MHA Program as an administrative resident at the University of Minnesota Hospital.

DT: It strikes me that would be kind of a competitive slot to get if there was only one residency position at University Hospital. Your other classmates spent their residency at other local hospitals?

GH: Yes, other local or national. Our students, then and now, spread across the country for their fellowships or residencies.

DT: What were your responsibilities as a resident?

GH: Fortunately, very little. [laughter] I remember sitting outside; my desk was immediately outside the CEO's office. The CEO then was a fellow name named John Westerman, who remains a very close friend. In fact, we're having a little reunion event for him this summer with a number of his past residents and people whose careers he's mentored. It was mostly an educational experience with problems assigned or tasks assigned as needed. One ongoing task I remember well was the handling of patient complaints, so it may have been something like that. Then, involvement in real things.

For instance, I was involved as the administrative resident in some of the original planning behind what now is the Phillips-Wangensteen Building. Actually, when I stayed on as a permanent member of the staff, one of my first jobs was to help get that building opened and operational.

DT: That's interesting.

I'm curious that you mentioned patient complaints because, in looking at the records from the Hospital, it seems like there was a new focus or a renewed emphasis on patients from the late 1960s in part due to the patients' bill of rights and, then, there was Patient Relations Department established at the Hospital.

GH: Yes.

DT: Can you talk about that? Was there really this extra attention on the patient?

GH: I think this really runs to the heart of academic health centers generally. I've no doubt that nurses and physicians and pharmacists for generations before cared a lot about patients. I don't mean to say they didn't, but the economics of academic health centers, university hospitals, and medical schools changed dramatically in the 1960s and early 1970s. Many university hospitals and medical schools were largely funded on state dollars up until that point. A transition began then where the hospitals and the medical school faculty became much more reliant on patient care income as opposed to being primarily funded by the state. So that put the hospital and the faculty in a more competitive position in order to do a good job. Competing, you have to do a great job of taking care of patients not only from the point of view of their clinical outcomes, but, also, from the perspective of them being customers. So I think that notion probably began to get traction in the late 1960s and early 1970s.

DT: From reading the Board of Governors minutes every entry or every other entry, there was more discussion of "are we taking care of the patients enough?" not just in a clinical sense but in other ways too, as with the patient satisfaction reports.

GH: Yes. I remember the very first Board of Governors meeting, in fact, as you say that. Part of my learning was to participate in those Board meetings, and help prepare for them, and follow through on those, as well.

By the way, you probably learned that the University of Minnesota Hospital Board of Governors was the first of its kind in the country.

DT: Yes. That was actually something I was going to ask you more about.

I was wondering, before we get into that, did you get a notice... I guess if you were only dealing with patient complaints that first year... I wonder if there was any tenor of the patients or whether the patients themselves were becoming more activist in looking for better care.



GH: Oh, no, I don't think so. I think patients long before I was ever in the hospital world would always come to hospitals and their doctors with very high expectations of good care and caring. I think that certainly continues to this today. I think there is today more probably consumer mindfulness and ability for the consumer to make choices based upon information that's available today that wasn't available thirty or forty years ago. I think there probably was more of a trusting relationship between patients and their doctor. That was almost automatic back then. That doesn't exist today. So I think there has been a change in that regard.

DT: You mentioned the Board of Governors. That was created at the end of 1974. Were you as students in the MHA Program exposed to the discussions about whether or not a board of governors would be established?

GH: No, the class in total was not, but by virtue of my being in the administrative resident position at that point in time, I got exposed to it, yes.

DT: Can you talk about what the rationale was for setting up the Board?

GH: Yes. Consistent with what I said a few minutes ago, the world was changing rapidly at that point moving from a mentality of being a state institution to the notion of being an institution that has to compete for its place in the market, recruit the best people, generate the revenue that's needed, all those sorts of important things. Universities, generally, aren't wired at the governance level to kind of give enough attention to an entity that has to compete in the marketplace with all the dynamics that were happening at the time and continue to happen in the healthcare.

So John Westerman recommended to the President of the University [C. Peter Magrath] and the Board of Regents that they set up, what in essence, was a subsidiary board to guide the Hospital through those new challenging waters.

DT: I saw, also, that there was some concern from the Joint Commission on Accreditation of Hospitals [Organizations], JCAHO.

GH: I don't think that was a primary driver, but, yes, the Joint Commission, at the time, was also looking at university hospitals across the country and saying if a standard of... Our seal is good governance. It's kind of hard to find that without the kind of board that was constructed here.

DT: Were you aware at all of how the Board was constituted, who made the decisions about who got on the Board?

GH: I was not asked for my opinion on that as a new student. [chuckles] But my recollection was that it was a process which involved several members of the Board of Regents, the President of the University, Lyle French and Dave Preston who were in the

vice president's office at the time, Cherie Perlmutter, as well as John Westerman and a few others that I'm sure they consulted with.

DT: I've actually met and spoken with Marie Manthey, because I was interested to see... Her appointment to the Board had created some consternation from the nursing faculty. I don't know if you remember any of...

GH: No, I don't remember that. I know Marie, but I don't remember the consternation.

DT: She didn't remember anything about the consternation either.

[laughter]

DT: It's just one of those things that's in the Board of Governors minutes.

Governors, obviously, is kind of a big, broad term. I wonder what the role and function of the Board ended up being, particularly vis-à-vis John Westerman and the hospital administration.

GH: Yes, yes. The Board did, because it was a new entity, kind of struggle with its most meaningful roles. I think things evolved, such that they became a point of accountability for management in terms of financial performance, in terms of quality performance, in terms of strategy in the marketplace. The Board of Governors also became a resource for the Board of Regents, sort of a safety blanket. We've entrusted a major part of the University to the care of this group of people that we have appointed.

There was some tension at times between the Board of Governors and the Board of Regents, as well. By virtue of their being there, the Board of Governors would perceive that sometimes the way the University at large does business doesn't fit well with how a hospital operating in a competitive marketplace needs to operate. For instance, we couldn't take advantage of national purchasing contracts that were evolving at the time. All of the traditional university civil service rules applied. All of those sorts of things created some issues and we ended up recommending to the Board of Governors that we do business differently in some areas than the rest of the University and that created some tension between the two boards. But, ultimately, those things all got worked out.

DT: So, ultimately, the Hospital was permitted to do things differently then, do you think?

GH: Yes, with some pain and some tension and some time. Then, what happened, as you know, over time, the market continued to evolve and the decision was made to align the Hospital with the Fairview system, which happened in 1997, I guess, and continues to this day. I was involved in that. I had left the University then, but was actually hired back by the University and the Fairview system to kind of put that deal together.

DT: I definitely want to come back to that.

I'm actually curious about hearing more about the increasing competition in the hospital marketplace through the 1970s.

GH: Yes.

DT: What accounted for that and what are some of the things that the Hospital had to do differently?

GH: I think what accounted for that was, historically, the University Hospital—this is true not only in Minnesota but across the country—was sort of granted two roles. One was to care for the poor and those without insurance. The second was to take care of the sickest of the sick patients. So that created a sufficient patient base for the students and the residents and the faculty over the years leading up to the 1970s, probably.

Beginning in about the 1970s, as there were fewer uninsured patients by virtue of Medicare, state Medicaid programs, etcetera, coming into play, that role diminished, at least for the University of Minnesota Hospital, less so for some other university hospitals. And the other parts of the healthcare system became increasingly sophisticated in their medical capabilities. The University did a great job of teaching students and residents, and they would go out and become private practitioners and join larger and larger groups, and those groups became competitive for the sickest of the sick patients, as well. So whether it was a major open-heart surgical program starting at Abbott Northwestern [Hospital] or a major cancer program starting somewhere else or the children's hospitals in the communities of Saint Paul and Minneapolis reaching another level, the sort of a natural evolution of the market took place and the University needed to respond to that.

DT: What were some of the strategies the Hospital used to respond to that?

GH: I think an increasing focus on the patients was certainly one of them. Reaching out across the state in developing closer relationships with referring physicians was another one. In some cases, that led to actual alignment of some of those physician groups or hospitals with the University in a more formal way. Hibbing and Red Wing are probably the two best examples of where that happened. I think continuing to invest in high-end technology. The transplant program which evolved at that point in time and the bone marrow transplant evolved as a national and international leader, both of them did, I think continued to secure a market position for the University. That continued to be more and more difficult as time evolved, as well.

DT: Was the Mayo Clinic much of a competitor in the Twin Cities for University Hospital? I know people talk about the Mayo Clinic down there [Rochester, Minnesota]...

GH: Right.

DT: ...but I wondered was it really serving any kind of competitive pressure?

GH: Not directly. Certainly, I think, people in the Twin Cities were always mindful of I can go to Mayo or I can go the University. That was true for rural Minnesota, as well, to a degree. There was actually very little sort of head-to-head competition between the University and Mayo.

DT: What about the arrival of HMOs? The HMO movement began. Actually, you mentioned it. Maybe you can talk about InterStudy.

GH: I think the thing that really was a game changer was you can call them HMOs; you can call them health plans, moving to different approaches which restricted patient's choice or which gave patients incentives to use providers that were more directly aligned with the other systems. So, that was a serious problem probably in the 1980s where the other systems aligned themselves more closely with health plans than the University did, and, frankly, because the University had a perception of being a high-cost organization and state of the art in terms of measuring, comparing costs and quality and value was not what it is today back then. It became more and more difficult for the University to articulate a position that said, "You really need to have us as part of your delivery system," if we were talking to the other health plans.

DT: I saw—I didn't realize if it was the 1980s. I assume it was the 1980s—the hospital price comparison studies that were being done. I guess that's part of what you're saying.

GH: Yes.

DT: Were there any discussions about the University setting up an HMO in the 1970s?

GH: I don't recall there being those discussions in the 1970s. The University actually did, for a short period of time, set up an HMO called the Primary Care Network—I want to say that was more in the early 1990s—which was probably too late. It only lasted for a few years and went out of business.

DT: I remember seeing with the Department of Family Practice beginning in the late 1960s, or right around the early 1970s, that the department had been trying to set up a group practice plan.

GH: Yes. They created what is now UCare.

DT: Yes.

GH: It was sort of part of the Department of Family Practice, but not really part of the University. There's a whole history there that probably we don't have time to go into and that I don't know completely. Only one person does, and he's no longer with us. Yes, I think, in some ways, that was a very forward thinking move on the part of...his name was Doctor Ed [Edward] Ciriacy and something that the whole of the University probably should have been paying more attention to at the time.

DT: Yes. I've read a lot of the material around the efforts to set up what became UCare, and there was a lot of resistance from the Minnesota Academy of General Practice...

GH: Yes.

DT: ...and the State Medical Society having concern about losing their patients.

GH: Public tax dollars competing with us, I'm sure.

DT: Yes. [chuckles] Ed Ciriacy is someone on my list who I wish was still around.

GH: Yes.

DT: You mentioned that University Hospital was always conceived of as this high-cost place that had the newest, most expensive technology. Were there particular technologies, do you think, that drove costs at the University Hospital? What were some of the biggest innovations, do you think in terms of medical technology?

GH: Oh, gosh, we can go back to the 1950s, before I was there and the whole world of cardiac surgery centered at the University of Minnesota. There's a wonderful history written from there; you've, no doubt, read some of those, as well. I think one moves from there probably, primarily, next to organ transplantation where Minnesota was the epic center for organ transplantation for several decades, obviously under John Najarian's leadership. I think the bone marrow transplant program certainly distinguished itself in those days as well, going back to Robert Good and some of his original scientific work and to John Kersey and Phil McGlave and Norma Ramsey and others building from there. I think if you looked deeper inside each department, you would find wonderful nuggets of excellence, as well. I think those were, probably, the reputation builders of the institution during those years.

DT: I noticed more generally in hospital medicine in that time period that it seemed to be new imaging technologies that were often introduced and, of course, this is maybe not so much a distinct feature of University of Minnesota Hospital, but I wonder what the consequence of having to purchase CT [Computed Tomography] scanners and, then, MRIs [Magnetic Resonance Imaging] did for the Hospital.

GH: We were expected to be the first to do those things, so, yes, there was more capital expense associated with it and, to a degree, or for a short period of time, some competitive advantage came along with that, as well. That probably did add to the operating cost base and the capital expense budget of the institution before it did for the others in the Twin Cities.

DT: As you said, the University Hospital was expected to always be at the front there.

GH: Yes.

DT: Nationally, it seemed there was a lot of concern from the mid 1970s onwards about rising hospital costs, healthcare costs. There was a move to have more cost containment. President [Jimmy] Carter, at one point, called for hospitals to voluntarily limit their price increases.

GH: Yes.

DT: Can you talk about what that moment was like and what it meant for the Hospital?

GH: Boy, that was such a fleeting period.

[chuckles]

GH: There was a time, indeed, where the thought was that regulation would be the solution to the healthcare cost problem. That proved not to be the case at all. Whether it's at the University of Minnesota Hospital or the others, the sort of artificial price constraints and things like that just don't reflect reality. Minnesota had a certificate of need process in place for a number of years. Basically, it was one of the first to conclude that even those sorts of artificial constraints on capital investment really weren't very effective either.

The chairperson of the Metropolitan Health Board, at the time, who became the chair of our University Hospital Board of Governors some years later... Barbara O'Grady was her name. I remember talking to Barbara about her conclusion that it really is the market that ultimately speaks and attempts by regulatory agencies to configure a healthcare system just were doomed to fail.

DT: As I understand the way that pricing worked in the healthcare industry in general is that prices are negotiated with third party payers and with Medicare and Medicaid, which I guess is the market.

GH: Well, prices are negotiated with third party payers, yes. Prices aren't negotiated with Medicare and Medicaid.

[chuckles]

GH: Those are really set by the Federal Government and state governments, respectively. But, yes, in combination, that is the market.

DT: Given that one of the national concerns was that it was Medicare costs that were rising, did the government try to de facto regulate by reducing the amount of reimbursement that it would give through Medicare? Was that ever used as a way to limit costs?

GH: What happened was from the inception of the Medicare program in 1965 until 1982 or 1983, Medicare paid hospitals based on costs. So whatever your costs were, you were able to pass those on to Medicare. Well, I guess it did take a while, almost twenty years, but it doesn't take a genius to say, "That's kind of a bad way to do business. The more you spend, the more you get." So they implemented something called a Perspective Payment System in which hospitals, beginning in 1982 or 1983, were paid a fixed amount per admission on a disease-adjusted basis. At virtually the same time, Blue Cross in Minnesota made a major policy change, again moving away from cost reimbursement to paying at a similar kind of approach: payment per admission rather than cost per patient.

Those were two game changers in the evolution of healthcare financing in the country, and certainly had its impact on the University Hospital, because it probably benefitted most from the old system where the more you spent, the more you were paid.

DT: Can you say any more about how diagnosis-related groups [DRG]...how the payment through Medicare was changed? Can you elaborate more on how that changed things at the Hospital?

GH: Imagine a situation where a patient is admitted in the old days for congestive heart failure. The more laboratory work you did, the more drugs you prescribed, the longer the patient stayed, the more therapy the patient had, the more monitoring technology that was used on the patient, the longer they stayed in the ICU [intensive care unit], all those things led to more revenue for the Hospital, any hospital. In the then new world of perspective payment and DRGs, you knew how much revenue you were going to get based upon the patient's diagnosis and, therefore, the pressure was on to reduce the length of stay or to reduce the kind of services that were provided to the patient to all that was medically necessary but not more. That was, as I say, a game changer in how hospitals and physicians and nurses and pharmacists needed to think about how care was delivered.

DT: Do you think it ended up having the effect that the government wanted? Did it noticeably reduce expenses, costs, or was the cost more to patient care?

GH: Certainly, the cost trend has continued, so I think the evidence would be that it had a moderating effect but not a problem-solving effect. In part now, think of the system in which, yes, we know how much revenue we're going to get for a patient that's admitted, but whether that patient is admitted ten times rather than twice, it still results in more revenue being generated. So that has now led, in more recent years, to different kinds of payment systems in today's world.

DT: Yes, I suppose if you're forced to discharge sooner, but then ultimately you have to re-admit them, then...

GH: Right. Or did they need to be admitted in the first place, all those sorts of questions are still out there.

DT: Obviously, the world of hospital and healthcare financing is complex, so it's good to have—I think I understand it—it explained clearly.

During the 1970s, it seems there were—at least from the records—a number of challenges, one of which related to the abortion services that the Hospital was providing. I guess in 1975, the Hospital eliminated second trimester abortions, and, then, with the appointment of Konald Prem as head of OB-GYN [obstetrics-gynecology], there was concern because he was prolife that he was going to affect abortion services even more.

GH: I remember Doctor Prem, but that played out just before the time that I joined the staff at the Hospital. It either happened before my time or I don't remember it well.

DT: The only other point was that there was the closing of the outpatient abortion clinic in 1977.

GH: That doesn't ring a bell either.

DT: Another thing that struck me was, talking about the Metropolitan Council, that in, I think it was 1976, they designated various hospitals in terms of their emergency service capability.

GH: Yes.

DT: And they'd given the University Hospital just a basic center designation and the Hospital or the [Board of] Governors were disappointed with that. Do you remember anything about that?

GH: I remember that a little bit. That was the beginning of the process of designating Level 1, Level 2, Level 3 emergency departments with a particular focus on Level 1 trauma centers. Back then, and it's pretty much continued to this day, it was really Hennepin County then, Saint Paul Ramsey now, Regions and North Memorial [Hospitals] that served as the primary trauma centers for the Twin Cities. The University never really did play that role, and I don't know that it would have been right for the University to try to play that role or to argue for a higher-level designation. I think the concern was that patients were going to get steered in ways that they shouldn't because of those designations. I don't know that that was a major problem.

Although, I do remember sitting in my office in what was then the Variety Club Heart Hospital looking out over River Road and a runner or someone had a heart attack and the Hennepin County ambulance came and scooped him away and right around the corner was the University Hospital Emergency Department and the patient was brought downtown. I actually went and checked.

[chuckles]

DT: That just seems counter intuitive when you've got a hospital right there.



GH: Yes.

DT: My sense is that the Met Council's process of designating was due to the efforts to do regional health planning.

GH: Yes, which is partly cost driven, also, back to that earlier concept.

DT: How else did regional health planning or efforts at regional health planning play out, do you think?

GH: That was this notion of certificate of need, as well, where before one started a new service or invested a certain amount of capital, you had to go provide testimony to the Metropolitan Council and the Metropolitan Health Board that there was a need for this service or for this particular expenditure. So that was supposed to create regional health planning, as well.

DT: You could demonstrate need because no other hospital was providing it, or there was no such...

GH: Or not enough.

DT: Yes.

How were relations between University Hospital and the other local hospitals in the 1970s?

GH: In the 1970s...if I could maybe throw in the 1980s in there?

DT: Yes, you can do the 1980s, too.

[laughter]

DT: I was going to ask about the 1980s anyway.

GH: The University's closest affiliates, largely because they participated in the teaching programs both for medical students and residents, were Saint Paul Ramsey Regions, Hennepin County and the V. A. [Veteran's Administration]. That constellation continues to this day. So those were the closest organizations.

In fact, for a while, there was an organization called the Minnesota Association of Public Teaching Hospitals that was formed, a brainchild of John Westerman again. That was largely focused on coordination of graduate medical education programs. But despite that, each of those organizations also had its own niche in the marketplace and we competed at the same time. We collaborated with those organizations.

I think the emergence of Abbott Northwestern as a major regional referral center probably created the most competitive relationship. There were a number of University faculty at the time who, for whatever reason, chose to go into private practice but landed at Abbott Northwestern. The cardiac program in particular was a landmark there.

I've always thought the children's situation in this community was unfortunate because Saint Paul and Minneapolis Children's Hospitals grew up, for whatever reason, in a relationship that became very competitive with the University or vice versa; whereas, most communities our size have one or two major children's centers, we arguably had four or five, which sort of dilutes talent and causes you to compete over the care of children, which is really unfortunate. We tried a couple of times to bring the children's hospitals and the University Hospital together. In fact, at the point where Minneapolis Children's and Saint Paul Children's merged, we sort of volunteered to be part of that so there could be one consolidated children's care system for the Twin Cities, but there were just too many politics surrounding that happening.

It was, indeed, through the late 1970s, and the 1980s I think in particular, where the capabilities of the other systems in town began to rise to a level, whereas, the University had that traditional role of we care for the sickest of the sick, others were moving into that territory pretty aggressively.

DT: Yes. I know this isn't a unique feature of Minnesota, but I know that in Minnesota, certainly in the 1960s and 1970s, there was a lot of tension between the gown and the town.

GH: The town/gown problem.

DT: Yes, town/gown relations. I wonder if that fed into this competitiveness that emerged between the different hospitals.

GH: I don't know that. I think that is evidence of it; I don't know that it fed into it. What you had was people in the community saying, "I'm trained at the University to do spine surgery"—or neurosurgery or to take care of patients with diabetes—"and here I am supporting the economy by taking the risk of being in business myself and, now, to my amazement, here comes the University supported by state dollars trying to take away my patients. It doesn't seem fair." That's sort of the classic description of the town/gown problem.

DT: And I guess, as you say, if the University is training these town physicians, the University can't claim these town physicians are inferior...

GH: Right.

DT: ...because they trained them. [chuckles]

GH: Yes, yes.

DT: Can you talk about the expansion and renewal of the University Hospital? I guess discussion began in the late 1980s.

GH: Actually, one of the things that Lyle French did going back, as I recall, to 1964 or 1966, was laying out a long range plan for renewal of the Academic Health Center starting with Unit A and going on to...I think Unit K was the last one in the alphabet. I kept those documents for a long time and kind of tracked them and nothing happened the way it was supposed to.

[chuckles]

GH: But, ironically, Unit J, which was the new University Hospital in those early 1960s plans, was targeted to open in 1986, and, lo and behold, that's actually when it opened.

DT: Wow.

GH: Nothing in between happened the same way, but that's actually how it played out.

That was a very, very difficult process of getting there. I'll go back to the town/gown problems in that regard.

There was no question that the University Hospital facilities, which, in some cases, dated back to 1913 and, in most cases, were 1950s vintage, were outdated. I now teach in a room that was once the pediatric intensive care unit that was only about twice the size of the room that we are sitting in which, for listeners, is probably fourteen [feet] by fourteen [feet]. The facilities were fast becoming out-of-date and an impediment, actually, to attracting patients and staff, physicians, nursing staff, and others.

But there was a long multi-year process of getting approval for what became Unit J, the new University Hospital, running through the late 1970s and into the early 1980s. John Westerman, Bob Dickler, Dave Preston, Cliff Fearing, I remember the four of them many, many, many, many, many hours at the Legislature convincing the Legislature to allow the University to bond for the bill using the state's credit card, [unclear] using the state's bonding capacity. Ultimately, the Legislature did approve that. Then, in a strange twist of fate, the University's credit rating was better than the state's at the point where we went to market to issue the bonds—I think it was 1982—and they ended up being issued as University of Minnesota bonds rather than State of Minnesota bonds, after all that work.

DT: [chuckles] But, then, it took a few more years for it actually to be built, right?

GH: Yes, yes. It opened in 1986, as I recall.

DT: At this point you were associate director, is that right?

GH: Let's see. I became the sort of the COO [chief operating officer], the director of operations in, I want to say, 1982.

DT: What do you do as COO? What's your area of responsibility then?

GH: Essentially, the operating budget of the Hospital, if you want to think of it that way. So everything from facilities to human resources to information systems, etcetera, etcetera, etcetera, falls into that category.

DT: I noticed in the Board of Governors' meetings that there was a lot of debate or changes around labor negotiations and contract negotiations.

GH: Yes.

DT: So that would have fallen under your purview then?

GH: Yes, it would have.

DT: I realize that in terms of labor, there's always contract negotiations. It seems, ongoing, but one of the things that struck me was that there was disagreement over or some kind of contention over whether the Hospital employees would be represented by AFSCME [American Federation of State, County, and Municipal Employees] or Teamsters, at some point. Can you talk a bit about where that conflict came from?

GH: Yes. All employees have the right to choose whether or not they wish to be represented by a union and in the public sector, there tends to be a lot of union presence. That was true across the University of Minnesota and, by virtue of being part of the University of Minnesota was true at the University of Minnesota Hospital, as well. Employees not only have the right to choose *if* they wish to be represented by a union but by *which* union. So there were, from time to time, elections held by the employees as to whether they wanted AFSCME or the Teamsters or others to represent them.

I mentioned earlier that part of the agenda that the Board of Governors took on was this notion of being able to compete in the competitive marketplace and be different where necessary from the rest of the University of Minnesota. So, over time, things evolved such that a lot of the human resource management policy-making was different at the Hospital than it was for the rest of the University; although, we were always part of the combined University negotiations for those contracts.

DT: I saw that there were efforts—this would have predated your residency at the Hospital but it continued afterwards—to establish a health sciences bargaining unit. I assume that was across the University, not just the Hospital. Were you aware of that or do you have any insights into that?

GH: I don't recall the health sciences, per se. I do remember discussion about distinct bargaining units within the Hospital. It didn't play out that way; although, for some of

the bargaining units... For instance one of them primarily involved healthcare jobs. So the vast majority of the members of that union were Hospital employees, so the negotiations became very Hospital centric, as a result.

DT: The nurses were represented by the Minnesota Nurses Association [MNA], right?

GH: No. The MNA tried to organize the nurses at the University Hospital on a number of occasions, but the nurses never voted to approve representation by MNA.

DT: Okay. That's interesting.

Then, I saw that the pharmacists... There was an effort—I don't know whether they were unionized—were represented by PEPOM?

GH: PEPOM, yes.

DT: [chuckles] They were represented by PEPOM [Professional Employed Pharmacists of Minnesota]?

GH: I think that's right, yes. That was a very small union compared to AFSCME or the Teamsters unions. Yes, that's right.

DT: This was also related to labor, I guess: the debates in the late 1970s or continuing throughout the 1970s about whether medical residents were students or employees. Was the Hospital involved with that or was that the Medical School who was negotiating...?

GH: More the Medical School; although, I actually did get tangentially involved, because when I was an administrative resident, my stipend did not include an income tax withholding. The IRS [Internal Revenue Service], for some reason, chose me to contest that case, and I lost.

[laughter]

DT: You had to pay a lot.

GH: So I had personal experience with that, yes. Well, I didn't have to pay a lot, because I wasn't getting paid much to begin with. [chuckles]

DT: I was talking to John Diehl this morning, interviewing him, and he said this continues to be an issue about the...

GH: It was, literally, before the Supreme Court last year, the Supreme Court of the United States last year.

DT: So it's been like a continual source of...

GH: I imagine you've talked to Keith Dunder and others?

DT: He's on my list. I haven't gone to him yet. I'm trying to go chronologically as much as possible. [chuckles]

Talking about nurses... There was nationally, but I guess at the state, concerns from the late 1970s onward about nursing shortages.

GH: Yes.

DT: How did that impact the Hospital? Were there genuine concerns?

GH: Oh, yes! Yes, absolutely. Those shortages ebb and flow, but it was a constant need, because our patients were as complex as they were, to have a great nursing staff and to be competitive in the marketplace so we could compete for that limited resource. That's a good example of where, sometimes, the policies that universities have don't work for their university hospitals. The university might have a wage freeze in any given year. You couldn't afford to have a wage freeze in a situation where you had a nursing shortage. So we argued that we can't live by those rules and have to have some different rules to live by.

DT: Yes. I understood that there was a lot difficulty recruiting nurses, I guess because it's a competitive labor market.

GH: Yes.

DT: There were concerns about the working conditions at the Hospital.

GH: Yes, yes.

DT: There was actually a nursing strike in 1984?

GH: No, I don't think so—not at the University Hospital.

DT: Okay, but maybe...

GH: Maybe elsewhere in the community.

DT: Maybe that's where it was.

I noticed that from 1985 onwards you see the introduction of debates over comparative work for hospital employees around gender equity.

GH: Yes.

DT: Could you talk about that?

GH: I do remember those. The state implemented—this was in concert with a lot of things that were happening nationally—the concept of comparable worth in which people in female-dominated jobs should be paid similarly to people in male-dominated jobs, a concept which is difficult to argue against. The difficulty was how do we measure the comparative value or comparative worth of what a nurse does compared to what a housekeeper does or compared to what a male-dominated profession like a pharmacist does. So that became a very difficult process. It was, again, an area where what worked for the University didn't really work very well for the Hospital. So we ended up going through our own comparable worth analysis using our own tools that had been developed more for healthcare professions.

DT: Was there any dissatisfaction on the part of either the faculty that you saw or among administrators about this notion of comparable worth? I understand that you said it's hard to argue against.

GH: I don't think there was ever any debate about the principle. Where the debates became centered was around the measurement part of it.

DT: It seemed like a lot of things happened around 1985. The physicians organized the University of Minnesota Clinical Associates.

GH: Yes.

DT: Can you talk about that and what they were before and, then, what function they served?

GH: It's a story that continues to evolve. This is, again, evidence of market-driven change and the University's need to respond to market-driven change. Before about 1985, every department within the University Medical School, and, in some cases, several units within a given department, essentially did their own billing, billed for the physician's services through their own unit, their own business unit. That meant that the new HMOs or Blue Crosses of the world had to deal with somewhere between eighteen and fifty-something different business units in order to do business with the University. So there was the Hospital and, then, there was Surgery, and Medicine, and Pediatrics, and Orthopedics, and ENT [Ear, Nose, and Throat], and Neurology, etcetera, etcetera, etcetera. That became very cumbersome and wasn't very effective for the University either.

So the physicians basically agreed to create something called the University of Minnesota Clinical Associates [UMCA], which would represent all of the faculty in contracting with the health plans...was their original mission. Over time, that organization has evolved to where it's now doing all the billing for all the physicians. It didn't start out that way; it's evolved in that direction. It's kind of the difference between being a medical arts building, where you happen to have a building where physicians practice, but they don't

really practice together, to being a true multispecialty group practice, and that's an evolutionary process.

DT: That's interesting. I've never understood what a medical arts building was. I've seen the name on buildings and what does that mean?

GH: It's just a place where physicians rent space but don't really have a relationship beyond that. The University was never that bad, but the fact that it had a couple dozen different billing units was an indication of sort an artifact of history that needed to be dealt with.

DT: Is this now being reformulated as UMP, University of Minnesota Physicians?

GH: The University of Minnesota Clinical Associates evolved into the University of Minnesota Physicians, yes.

DT: What's the difference between...? You mentioned the evolution so that Clinical Associates were doing the billing. Did it then become UMP? What led to the name change and what did it mean substantively?

GH: You have UMCA [pronounced oom-cuh]...

[chuckles]

GH: It started out, originally, just as a managed care contracting organization. It didn't do the billing itself, and it didn't operate clinics together. The physicians didn't really use it as a forum to set strategy or to measure quality or to coordinate care. Those are the things that have evolved over time as UMCA. The managed care contract entity has become UMP, the academic multispecialty group practice.

DT: I see. That helps explain things a lot.

GH: There are a number of key people who probably are on your list who were instrumental in guiding that change. I think Doctor William Krivit was actually the first chair of the University of Minnesota Clinical Associates. The transition that we just talked about was led, in large part, by Doctor Roby [C.] Thompson, who, no doubt, is on your list.

DT: Yes, he is. I'm glad that I know a bit more about what that transition was before I try to talk to him. [chuckles]

Changing track, but, also, around 1985, can you talk about the impact that HIV-AIDS [Human Immunodeficiency Virus-Acquired Immune Deficiency Syndrome] was on the Hospital?



GH: Yes. I remember hearing an infectious disease specialist named Doctor Frank Rhame, R-h-a-m-e, talk about this thing called HIV and what a sort of scary thing it was. I think we, like all hospitals and other healthcare provider organizations, went through a learning curve with AIDS...a lot of fear of the unknown for a period of time. We had an incident or two that I recall involving an HIV positive patient and the assault of a nurse. There was a lot of debate about what should or shouldn't happen in the operating room, should surgeons have the right to choose which patients they operate on, all those sorts of questions. There were a couple, two, three kind of rough years there before people really understood the nature of the bug itself.

DT: Given this was such a new entity, I'm guessing there weren't any models for University Hospital to model themselves on.

GH: No. No.

DT: Were there any discussions among organizations of hospital administrators or the Minnesota Hospital Association?

GH: Oh, sure, yes, I think in the medical professional societies as well as in the institutional societies like the hospital associations. There was a lot of discussion about those sorts of things.

DT: Were there any instances of transmission of HIV to hospital employees?

GH: I don't recall there being any at our Hospital. There certainly were nationally. Fortunately, that number was very few nationally. That's what everyone was concerned about, of course, for a period of time.

DT: Yes, I was looking at the Board of Governors minutes and I remember probably in 1985, 1986, where—I don't know if it was Frank Rhame—someone had talked about there were news reports of three cases of transmission. I guess in the initial discussion of it, it wasn't made clear that this was not at University Hospital, that this was somewhere else.

GH: Ah.

DT: It created a stir.

Eventually, the hospitals nationally and here developed procedures and protocols for dealing with HIV-AIDS. Did that end up having a significant impact on the cost of operations? Was it just a regular part of doing business?

GH: It became a regular part of doing business. In the grand scheme of things, the additional cost involved with the isolation techniques and that sort of thing for those patients was not really a major factor in the cost of healthcare delivery. The process now

and certainly the incidents of the disease has had a significant impact on the healthcare of the country, and more so in other countries.

DT: Yes. It looked like the University was doing a lot of trials or a relative number of drug trials around HIV drugs in this early period.

GH: Yes.

DT: So it was seeing, potentially, a lot of patients?

GH: Yes.

DT: We've talked about John Westerman as Hospital director. What was Edward Schwartz like, because he replaced Westerman, didn't he?

GH: Yes. John Westerman became the CEO of what was the Allegheny Health System in Pittsburgh [Pennsylvania], which, after John left, long after John left there, remains to this day as the largest non-profit bankruptcy in the country caused by a couple of John's successors in Pittsburgh.

Then, Ed Schwartz replaced John, in 1982 I guess. Then, Bob [Robert] Dickler replaced Ed Schwartz in 1987 and I took over from Bob in 1992.

DT: Was there any major differences in their style of running things?

GH: They were all wonderful people and I was privileged to work with and for all of them. Obviously, individual people have different ways of doing things. Westerman was and is a visionary, very broad thinker, and, in some ways, established the University of Minnesota along with the MHA program as a leader in healthcare management, healthcare leadership. Ed was probably more operations oriented. He came from the University of Michigan where he was the COO, as I recall, so he brought him a little bit more of an operational focus.

DT: How much interaction has the Hospital director, through Westerman, Schwartz, Dickler, then yourself, had with the State Legislature?

GH: A lot, especially in the early years when the Hospital received more of its budget in the form of a state allocation than it did in the later years. So there was a lot of interaction with the Legislature. Then, during the period where the legislative authority to build Unit J, the new University Hospital, came up, it was a *very* intense time of interaction with the Legislature. Bob Dickler was probably *the* key figure there.

DT: Over your years at the Hospital, did you notice any significant change in the way the Legislature approached or how it viewed the Hospital?

GH: [pause] I don't know that I would say that there was sort of a general trend there. Legislatures change with the times for many reasons. I think, on balance, the Legislature appreciated the University Hospital as part of the Academic Health Center's part of the University and did what it could.

DT: How about changes with the senior vice president? Obviously, you talked about Lyle French. Neal Vanselow replaced Lyle French. Was there any, I guess, change in the relationship between the University Hospital and the AHC's office with that transition?

GH: Not really. Again, those people were always very supportive. Lyle French was a person who couldn't be replaced. I'm sure you've heard that from many others, because of who he was and the first person in that office and the qualities that he brought. He was certainly always very supportive of the Hospital.

The Board of Governors was formed while Doctor French was vice president. So that sort of introduced a new dynamic into the equation where the hospital CEO kind of had two bosses. One was the vice president for health sciences and the other was the Hospital Board of Governors, but the vice president was always a member of the Board of Governors and there was never any major conflict there either.

DT: In 1992, you were director of the Hospital, CEO of the Hospital.

GH: Yes.

DT: That was around the case with John Najarian and the ALG [Antilymphocyte Globulin] situation.

GH: Yes.

DT: Did that impact the Hospital at all?

GH: Yes, it impacted everybody. John Najarian was such a towering figure in many ways. The transplant program was the signature program of the Hospital and had been for twenty-five years or longer. It had to affect everybody and it affected everyone as much psychologically as it did otherwise. There was sort of a loss of confidence externally in the University because of that investigation and I think a loss of confidence internally that this could happen at the University.

DT: Yes. It seems to have been a difficult time. I guess Robert Anderson, who was v.p. [vice president] for just a year, left amidst that.

GH: Right. He resigned after a year over that incident.

DT: Yes.

GH: He simply couldn't tolerate the stress that it created and he felt the crisis of conscience, as well.

DT: I understand the psychological impact and the issues of that kind of trust. I wonder...did it have any impact on the day-to-day operation of the Hospital and any particular challenges it introduced?

GH: No, I don't think it affected how care was delivered or anything like that. No. No. It was more a cloud that hung over the institution for a *long* time.

DT: Something else that if you can explain... The University of Minnesota health system was created in 1993 and that was the joining together of the Hospital and clinics and the clinical associates?

GH: Right.

DT: Can you talk about why that coming together happened?

GH: That was another step in the evolution of needing to respond to what was going on in the marketplace. We wanted to make sure that the Hospital and the physicians were acting in concert with one another, had the ability to sign health plan contracts jointly and, more importantly, were thinking as one rather than, as had evolved in some other places, as a highly competitive relationship between the faculty and the Hospital. Should the faculty own its own radiology, its own ambulatory surgery center, that sort of thing? We wanted very much to avoid that, so sort of on the heels of the physicians coming together in a new way, we wanted to bring the Hospital and the physicians together in a new way, as well.

DT: Did that end up being a fairly straightforward transition? Was there any reluctance on the part of the physicians to merge?

GH: You know I don't think there really was. It wasn't a true merger in the literal sense of the word. It was creating a new vehicle for the physicians and the hospital to work together. No, there was not a lot of resistance to it.

DT: Within the system then, did that incorporate some of the affiliated hospitals that the University and the AHC had been working with in previous years? I guess who else was in the system?

GH: Not Hennepin and not Saint Paul Ramsey, not the V.A. [Veterans Administration], but the system did encompass the relationships that we had built in Hibbing and Red Wing, at the time, where either the Hospital and/or the physician practice had agreed to align itself with the University.

DT: One of the things in thinking about the bringing together of the clinical associates with the Hospital, I'm curious... Does the Hospital have the same mission as the faculty

does in terms of what its primary responsibilities are, particularly in terms of the balance of patient care versus teaching versus research?

GH: Yes, it does. Part of the mission, like any university hospital, is to support education and research, and adopt that and embrace those missions, along with delivering great patient care. Yes, there's not really a difference there. There may be a difference in emphasis. There may be individual faculty members who spend most or all of their time in research or most or all of their time teaching, but, at the highest level, it's important that the mission be shared between the Medical School/faculty and the Hospital that they're primarily working in.

That was, of course, one of the major issues as the Fairview relationship was contemplated, which is probably where you're going next.

DT: [chuckles] That begs that question—we're jumping the gun a bit—why the Hospital was sold. Did that change once Fairview took over the Hospital?

GH: I think others could probably comment on that better than I can, because I wasn't there then, not working there everyday like many others have since. Certainly, in those early years after the Fairview relationship was developed, there was a lot of concern about, does Fairview really understand what it means to be an academic health center and to be operating a hospital within an academic health center? Yes, there were always those questions that were raised, sometimes, I think legitimately and, sometimes, as an excuse for somebody being unhappy about something else.

DT: [chuckles] Since I'm in the Surgery Department, I'm at some of those meetings and it's still a question that gets asked. I'm sure it's not just in our department but elsewhere.

Did your responsibilities change once the system was created? Was it different to when it was just University Hospital and Clinics?

GH: It was different in that when I went to bed at night and got up in the morning, I needed to be thinking not only about the Hospital but, also, about the faculty practice organization, about the University of Minnesota—I don't recall—Physicians, at that point, I think it probably was, UMP. I spent more of my time, in my case, in some cases learning about the faculty practice organization. Now, it didn't last very long, because the Fairview relationship kind of followed quickly on the heels of the forming of the University of Minnesota health system.

DT: Yes. Is it obvious that the person who had been CEO of the Hospital would also, then, become CEO, president of everything, when, given that your experience before hadn't been in faculty practice? Or did you have people underneath you that...

[chuckles]

DT: ...could help you figure that out?

GH: Was I even qualified for the job?

DT: No! I'm just...

[laughter]

DT: ...curious. I just realized, oh, those are, as you say, two different tasks.

GH: Yes. I think in today's world, it would be much more likely that a physician would occupy that leadership role, simply because there are more physicians in more leadership role these days than there were back then. Fortunately, the relationship I had in particular with Doctor Roby Thompson, at the time, was a very collegial kind of thing. It wasn't like I was his boss in the literal sense of the word. There was not an issue there. I think that's probably why the physicians went along with it was that they trusted the leadership team that had been put together.

DT: It's great because, when I think about the much earlier history of hospitals in the U.S., there was this classic tension between what the hospital administrators wanted and what the physicians wanted.

GH: Right.

DT: As it's stereotypically told, never did they get along. Here, we have a situation—this is many decades later—where it does seem very collegial. I wonder if that's just Minnesota or if that's something that the relationships between administrators and physicians have?

GH: I think that was a function of the cast of characters that were working together at the time. In a lot of ways, I actually point back to John Westerman for establishing the culture of collaboration with the physicians and with the Medical School and the faculty practice organization. That carried on for a long, long time. I think with the transition to Fairview, that was certainly one of the concerns, that now there was a group of people coming into leadership positions who didn't grow up with that DNA [Deoxyribonucleic Acid]. Would they be able to develop the kind of understanding and relationship that's needed?

DT: What were the biggest challenges that you faced when you were president of the health system?

GH: I think making sure that the Hospital and the faculty practice organization were working together as one. That was actually not a challenge. The bigger challenges were external, continuing to find the right place in the market, and the cloud that we talked about before around the ALG matter was present every day.

DT: Do you think that that cloud made it more difficult for the Hospital to be competitive?

GH: I think it created an argument which others could use to decrease trust and confidence in the marketplace. Just simply reading day after day, week after week about what's going on over there with the ALG thing caused people to say, "What's really going on over there?" The other thing it did is it created the internal crisis in confidence that we talked about before, as well.

DT: What led you to leave that position? You left in 1995?

GH: Yes, I left in 1995 in that role on a Friday and I came back the following Monday, as a consultant to the University and to Fairview to put that relationship together.

DT: Let's talk about that relationship. What was the rationale behind selling the Hospital to Fairview?

GH: That the University Hospital and its six percent market share—three percent market share in the Twin Cities—did not have the position in the market to compete in a situation where systems of twenty-five and thirty percent market share were going to be the norm. Even as the great University Hospital, we were too small.

DT: Had that market share declined significantly over time or had it always been that?

GH: It had always pretty much been that. It was never twenty percent. It was always in the middle single digits.

DT: I suppose when the Hospital is marketed as a place that treats the sickest and the indigent prior to Medicare and Medicaid, of course, it's not going to take a majority of cases. By virtue of its tertiary function then, it's going to be small.

GH: Right.

DT: Were there any other potential solutions that were looked at to get the system out of the fix that it was only a small part of the market share? Were there other things that were considered?

GH: That was part of the statewide outreach program, the development of the relationships in Hibbing and Red Wing and less formal relationships that evolved elsewhere. That was part of the coming together of the physicians into the faculty practice organization. That was part of the coming together of the physicians and the Hospital into the University of Minnesota health system. That was part of the reason for creating the Board. That was part of the reason for focusing on efficiency and human resource management and supply management like we talked about before. But despite all of that, the conclusion was that it was going to be a high-risk proposition for the University to stay in the hospital business. There was significant debt that was associated

with the building of the new Hospital. It opened in 1986. The University concluded that it didn't want to put itself in the position of having to use other revenues, tuition revenues or something, to pay off that debt. So the safer thing to do, so to speak, was to join with another system.

There was debate. In fact, there were two proposals that the Board of Governors first deliberated upon. One was from the Abbott Northwestern system. I think it was called Allina by then; I'm not sure. The other was from Fairview. I worked on the Fairview proposal and other people, mostly from Allina obviously and their own consultants, made a proposal to the University, as well. The Board of Governors recommended to the Board of Regents that the Fairview proposal would be more favorable to the University.

DT: My sense is that the University of Minnesota wasn't the only university to sell its hospital in this period, that this was happening in other cities, too.

GH: Yes.

DT: Do you think this was more of a national phenomenon, the idea that it's hard for university hospitals to sustain...?

GH: Yes, I would say there were two sort of major strategies that evolved probably in the ten to fifteen years before the Fairview decision. There were some universities that said, "We need to turn ourselves into that twenty-five percent market share player. So we need to be out acquiring other hospitals. We need to be very aggressive about those things." So you find today the University Hospital in Cleveland [Ohio] or the University of Michigan in that situation. I don't think the University of Minnesota was ready for that. In fact, it was very difficult to get approval even for small relationships like the one that we built in Red Wing. I think part of the thinking was the University of Minnesota, for whatever reason, was not able to allow its Hospital to be as nimble as some of those others were, and they may have been starting from a stronger market position already; hence, the conclusion by 1996, that it was too late. The other factor was the Twin Cities' market matured much more rapidly than some of those others that I talked about. So by 1996, 1997 at six percent market share, other systems already formed a lot of debt on the books. Conclusion: better to join another system. Then Fairview versus Allina was weighed, and Fairview was chosen.

DT: You mentioned just a moment ago that it was difficult to form even the smallest of alliances with other hospitals outstate. Where was the opposition? What was the difficulty there? Was it the Legislature that would say, "No, we don't want this formed?"

GH: A lot of it was back to that town/gown thing. What's the University doing using state dollars to buy physician practices in a community where I—other system X—am also present? It was a lot of that. That's just not what universities are supposed to be doing. You're out there competing with us and you're using tax dollars to do it. So it became very difficult for the Board of Regents even to kind of deal with that constant



barrage of criticism that they would receive over, even what seems like today, small competitive initiatives.

DT: Do you think that there was something distinctive about that situation in Minnesota, or is your sense from colleagues at other institutions that other universities who were trying to do outreach were having the same kind of problem with town/gown?

GH: Oh, town/gown is everywhere. The solutions to it in terms of competing in a changing marketplace played out differently. In some cases, it was let the hospital loose and let them do their thing. In some cases, it was we'll continue to just try to struggle along and build six percent to eight percent. In some cases, it was join another system.

DT: Was there opposition to the decision to sell the Hospital to Fairview from faculty, for example?

GH: I think there was a lot of concern—naturally so—in particular around that mission question that you were asking about earlier. Will Fairview be committed to the teaching and research mission, which is a big part of who we are and what we're supposed to do?

In addition to that, there were concerns expressed by unions. How will this affect us? Obviously, every employee from the senior administrators to the folks doing the hands-on care and others were wondering, how will this affect me? That's a very unsettling proposition.

DT: Did you leave so that you could be a consultant and that would make it easier for you to...? By not being president were you freed up to have more of a role in the...?

GH: Actually, I think I was, because I was hired by both Fairview and the University. That was something of a known commodity to the Fairview leadership people, as well, somebody that I think both could have confidence in, would help come up with the right answer that would serve the interests of both organizations.

DT: One other question I was going to ask... Given the mission of the University Hospital, its distinctive clear mission, and what's going to happen to that when Fairview comes in... Was there anything in the sale that kind of laid down what Fairview's responsibilities would be in terms of that mission?

GH: Oh, yes. The documents were negotiated over a painful many months...did as much as they possibly could to make sure that Fairview remained faithful to the mission. That ranged from certain kinds of financial commitments to maintaining the hospital as—the operative word at the time—a flagship institution offering the kinds of programs that would be expected of a major national academic medical center, a regional referral center. A lot of time and pain went into working those things out. But, sometimes, whatever is written on paper doesn't really tell you what happens the day after the paper is signed. People have to go through a learning curve, an adaptation curve.

DT: So once the sale was complete, did your role as consultant end or did you help with the transition, too?

GH: I was not very active afterward. I ended up sort of being involved in a number of things afterward, but the actual implementation of the new affiliation was left to the people who were in the jobs that they were in at the time.

DT: What happened to the Board of Governors?

GH: The Board of Governors went away and was replaced by a new Fairview University Hospital Medical Center Board, so just as Fairview had a board and Fairview Southdale, then Fairview Ridges had a board at the Fairview University Medical Center. Today, they're called the University of Minnesota Medical Center. As I recall, there were a few of the board members who ended up being put on the Fairview system board. That was one of the things that was negotiated. A couple of the board members ended up on the Fairview University Medical Center Board. So as individuals, they didn't all go away, but as a governing board, it went away, because it was appointed by the University of Minnesota previously and that was no longer appropriate.

DT: Who were the key figures in making the decision to sell? Frank Cerra came on as vice president of the health sciences in 1996 is my understanding.

GH: That seems about right, yes. The key figures originally, the sort of respective CEOs, were Rick Norling at Fairview and Bill [William] Brody, who was then the vice president for health sciences at the University. So the two of them were in those leadership roles. Ironically, for different reasons, they both left those roles and moved on to what I guess they thought would be greener pastures shortly after the shaking of the deal. So that left other people like Frank Cerra and Bill Maxwell and others at Fairview and at the University to put the finishing touches on things and to actually implement it.

DT: But it was actually initiated by Brody and Norling?

GH: Yes.

DT: We've covered a lot of ground. I wonder if there's anything else that you think is important to share about the history of the Hospital.

GH: Oh, we could talk for days...

DT: [laughter]

GH: ...especially if you keep asking the good questions that you've have. You're stimulating a lot of good memories for me.

We've touched on the importance of the University Hospital and its commitment to all three missions: patient care, education, and research. In many places there was a lot of

tension between the hospital CEO's office and the dean of the medical school's office, for instance. That was really not the case at all at Minnesota either. I had a chance and my predecessors had a chance to work with a lot of people who were very collaborative as deans. I don't know if David Brown is on your list?

DT: He is on my list, yes.

GH: If you're talking about a history of the Academic Health Center, obviously, you have to talk about deans, as well, not only in the Medical School but in the other schools. I guess my message would be I would want to emphasize the great collaborative relationships that we in the University Hospital administration had with the deans, especially in the Medical School.

DT: The people I have on my list are more on the medical side and, obviously, the people who led the Hospital. I'm curious about Nursing. I think it was Barbara Volk Tebbitt who was director of Nursing Services, but she, unfortunately, has passed away. I wonder who were the other nurses in leadership positions and what were the relations with the Nursing faculty?

GH: The Nursing faculty... Marie Manthey would certainly be on that list going well back. Actually, there are a couple Nursing leaders that we probably should mention. When I first started, strangely enough, the director of Nursing at the University Hospital was not a nurse. It was a woman named Donna Ahlgren, A-h-l-g-r-en. I think the fact that Donna was not a nurse actually did create some consternation on the part of the faculty in the Nursing school, in retrospect, not surprisingly so. [chuckles] She was a great person. Sadly, she died very young. She left her role and went into our MHA Program. We rehired her, and she was actually the original building project director for what became Unit J. Then, she very sadly and suddenly died at the age of forty or forty-one [Donna Ahlgren died October 4, 1982].

A fellow named Mark Haney took over that role and Barbara Tebbitt—who I actually had worked with at Methodist Hospital back to the early part of our conversation—became director of Nursing. I could name a number of other key people in that regard, as well. Joanne Disch would certainly come up. I think Joanne, actually, is the person who is most collaborative with and most highly regarded by the Nursing school, because she herself came from an academic background and was a Ph.D. and today is in a major leadership role at the school still.

DT: She's definitely on my list. I know that she became director in 1991 of Nursing Services. Was she also at the Hospital before that time?

GH: No. She came to us from, oh, gosh, it might have been the University of Alabama, or it might have been the University of Wisconsin; I'm not sure. I don't know what the order was but she'd been at a number of other universities and came just terrifically well qualified to us.

DT: I've met her. I haven't interviewed her yet. Everyone speaks highly of her.

That's one of the things that kind of jumped out at me when I was looking at the history of the School of Nursing, that the relations between the Nursing faculty and the nurses working at the Hospital was, sometimes, strained. I think this was also something that Marie commented on.

GH: That's not unusual in an academic center either. It was not an impediment, by any means.

DT: What about Pharmacy? Pharmacists are another important feature in the Hospital.

GH: Yes. Good relationship over the years with the College of Pharmacy. Our Pharmacy director was, for most of the time I think, in a faculty leadership role in the dean's office, as well. So that was a good relationship. At times, it can be tense again because there's a lot of money in pharmaceuticals and where does the money flow and those sorts of things, but those all get worked out.

DT: I know that pharmacy education changed significantly even in the late 1960s with the clinical pharmacy movement.

GH: Yes.

DT: Did you see that transition happen?

GH: Very much so, yes.

DT: What was the [unclear]?

GH: Probably the key figure in the University Hospital in that regard was a fellow named Paul Abramowitz, who is now the Pharmacy director and associate dean, I believe, still at the University of Iowa. Paul really led us through that transition process where pharmacists sort of moved from that little room in the basement onto the patient care units and were an integral part of the patient care team. I was quickly sold on the notion of what a clinical pharmacist can contribute to patient care, both from the quality and cost standpoint.

[break in the interview]

DT: My primary research area, aside from AHC, is in pharmaceuticals and pharmaceutical history. As you say, pharmaceuticals are an expensive part of health care. At least in the 1970s, pharmaceuticals weren't so much of the budget but, now post 1990, by the end of the 1990s, they were costing insurers more than even the hospital costs, which is quite staggering.

GH: Right.

DT: So the Hospital pharmacist, who is making decisions about hospital formulary I assume, has an important financial role.

GH: Yes. That's why I say the impact on both quality, right time, right drug, right dose, as well as the cost impact was something that I thought, like I said, was quickly sold on.

DT: Obviously, medical residents train in the Hospital and the Nursing students. I know the clinical time that Nursing students spend in the Hospital changed significantly in the early 1960s. But are the Pharmacy students also trained in the Hospital? So the Hospital has a function not just in the education of physicians but, also, all the other health sciences, too?

GH: Oh, yes. Absolutely. Yes, yes. I don't think we had any Veterinary Medicine students but...

[chuckles]

GH: That's what an academic health center is really all about. It's the bringing together of those professions in a way where each learns from the other and the hospital is the lab more so then than now, perhaps, because so much care is delivered on an outpatient basis. The hospital is the lab for that joint learning.

DT: I realize the creation of the Academic Health Center predated your arrival at the Hospital, but I wonder from talking to John Westerman in your time in the Hospital Administration Program, do you get the sense that that shared educational mission of the Hospital/AHC...that something changed in that responsibility with the formation of the AHC? Like before the AHC, then every school was kind of doing its own thing and there was less of this team concept?

GH: Yes. I compare Minnesota to other universities that I've had the privilege of working at over the years. The team concept was never more evident than the value of it, never more evident than at Minnesota than the other places that I've been at. It's a real difference maker.

DT: That's something that was one of the rationales for reorganizing the health sciences into the AHC, so I know that that's something that Frank Cerra will be very happy to hear, that that's something that was noticeable about Minnesota, that the AHC did succeed in that level.

GH: Yes. Yes, by all means.

We mentioned John Westerman. He's still around.

DT: Yes. He's on my list. I was just joking with John Diehl earlier that I wanted to interview him last summer. Then, I thought why would I go to Florida in the summer if I can go in the winter? [chuckles]

GH: He'll be here, actually visiting...

DT: Good.

GH: ...with a bunch of old colleagues the last week in June and early July.

DT: Great. My plan is I wanted to do a couple of local interviews around the Hospital first, and, then, I do want to actually go to Florida and do some research, too. So I'm planning to get in touch with him soon. That's good to know that he'll actually be here.

GH: The other group that I haven't mentioned that, oftentimes, doesn't get mentioned... We talked about physician leaders and others but there were also a lot of Hospital Department leaders: Paul Abramowitz in Pharmacy; Joanne Disch... I could go on and on to the Biomedical Engineering Department, the Medical Record Department, etcetera, etcetera. Those folks were also a very tight group and a big part of the success of the organization for a long time.

In fact, we just lost one of them this last fall [October 20, 2011]. We had a little reunion to remember him. His name is [Richard] Carter McComb. We had, I think, forty people come to that—we met over in the Campus Club—many of whom hadn't seen each other for fifteen or more years. It was a very warm event with people sharing a lot of great memories from those days.

DT: This is why my list just keeps on growing.

GH: Yes, I can imagine.

I was very lucky to work with many great people back then, is probably my summary statement.

DT: You've mentioned a lot of people that, clearly, are on my list or need to be on my list. Is there anyone else that strikes you that I must talk to?

GH: I should probably look at your list to know that. Is Bob Dickler on that list?

DT: Yes. I don't suppose you have contact information...?

GH: I do.

Bob [Robert] Baker?

DT: No. I know his name is there in the... [Board of Governors minutes]

GH: He actually wasn't with us at the University Hospital for a very long time, but he went on to a *very* prominent national leadership position, which, by the way, many of John Westerman's progeny have done. That's why we still get together a lot. Bob Baker became the president of the University Health System Consortium, a collaboration now of over one hundred university hospitals from across the country. That was actually John Westerman's idea that that organization be formed. Baker then became its first and long-term executive.

Is David Preston on your list?

DT: He is on my list, yes.

Bob Dickler is high up on my list, but I haven't been able to... I know he went to the AAMC [Association of American Medical Colleges] afterwards.

GH: Right.

DT: If you're willing to share his contact information that would be great.

GH: Yes. We probably shouldn't do that on the recording.

DT: No, no. That's fine.

[chuckles]

DT: Thank you so much. This has been great.

GH: Great. Thank you. It's an important project.

[End of the Interview]

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