

The Norma Berryhill Distinguished Lecture

**WHAT WE'RE LIKE WHEN WE'RE AT OUR BEST
AND TODAY'S REALITIES**

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It is a great privilege and honor to be selected to give the twenty-fifth Norma Berryhill Lecture. It honors a woman who has earned the respect of all of us. If Reece Berryhill was the architect of the four-year school and the creator of the hospital, Norma was the guiding force who championed the sense of community, warmth and civility that has long characterized this great school. In fact we find in these opening moments of the school the two features of the school on which I want to focus today: First, the creation of a four-year school whose explicit mission is to serve the people of the state, and second, the historic tradition of the school to value a sense of collegiality and the ability to work together. These commitments to mission and to community have distinguished UNC from its Berryhill beginnings. They are how we act when we are at our best. But are they relevant in our current highly commoditized, mercantile environment? Or are they simply a historic beginning, however idealistic, to a new set of realities?

A NEW SET OF REALITIES

It is summer of 2009, and we are making evening rounds at UNC.

In Labor and Delivery, an uninsured patient is successfully delivered, and just a few floors down a VIP is successfully cardioverted. The hospital has no available beds, and family members in the ER continue to ask, “When will my mother be admitted?” The ER physicians grumble, “When will the Hillsborough facility be completed?”

Andrew Greganti is back in his office after a full day in the clinic. He is trying to decide if he should return his calls to his patients—18 in all—or fill out insurance requests for justification of tests that he’s ordered. One of his general medicine colleagues puts his head in the door and says, “Having a good time yet?” and then adds sarcastically, “Just like the old days, huh?”

Todd Peterson has just finished a session with Gary Park. They will announce another 3.5% reduction to all budgets tomorrow. Just another day in the office for them, but sure to bring protest from the chairs.

Meanwhile a news flash interrupts all television programs in the area to announce a fire in an industrial plant outside Fayetteville, with at least 15 people being airlifted to the UNC Burn Center. Bruce Cairns and other clinicians can plan on an all-nighter. Not the residents though—they're protected by an eighty hour week. How did we get to easier work conditions for residents than faculty?

Bill Roper has just finished his dinner and tells Marianne our uncompensated care just rose to \$269 million/year.

And Tony Meyer is just finishing a meeting with the most clinically productive surgeons, who are unhappy with their pay. They want their compensation to match their productivity. Why be paid at 25% MGMA standards when you meet their 75% standards for productivity.

Rick Boucher is returning to his office to find the results of a new compound's effect on the viscosity of mucous on cystic fibrosis patients, the most promising thus far. He's been down this road before, but just maybe...

Donald Spencer is reviewing the details of an agreement with IBM to create a huge data warehouse on diabetes. While it has great potential clinical significance, it has great economic upside as well.

Etta Pisano is working intensely to create an accelerated process for product discovery that would bring UNC in step with other academic leaders who have forged ties with industry. And perhaps move us to the forefront.

Meanwhile, the larger community is less sure of these industrial relationships. Jerome Kassirer's [Doctors] On the Take keeps flying off the shelf in the bookstore.¹ The Runge committee on Conflict of Interest remains in deliberation. Many faculty are acutely aware of Grassley's brutal attacks on several of the nation's prominent psychiatrists and their alleged large payments from industry.²

In Washington, Barack Obama is reviewing his day with Michelle and frankly expressing concerns whether the compromises needed are "worth the squeeze". In an effort to bring the pharmaceutical industry, hospitals, physicians, and the insurance industry in line he has made many concessions. "You know, Michelle, there are just too many people making money off of healthcare to bring them all in line."

Max Baucus is huddled with Olympia Snowe to see if they can make the “numbers” work. Can they legislate medical loss ratios (the percent of premium spent on health care), and the percent of people needed to be covered in a State, to make sure that insurance companies meet their social obligations?³

Meanwhile, influence peddling continues. Alonzo Cantu, the founder of the Doctors Hospital at Renaissance, and a heavy contributor to both political parties, has just hung up the phone after being reassured by the Speaker of the House and key members of the Senate Finance Committee that they would not limit majority ownership of hospitals by physicians. You will recall that this hospital was featured in the June issue of The New Yorker, which posited that the physicians over-ordered tests and procedures because they got both their fees and a share of the hospital profits.⁴

What are we to think of this? Every episode listed above plays out on the balance sheet of the medical school and the healthcare system. Every one from Chapel Hill could be viewed as a potential point of conflict between and among faculty or between faculty and industry, or faculty and administration. And the vignettes from Washington represent not only distrust between parties but the classical conflict between self-interest and public good.

Could the Chapel Hill experiences ever be viewed as consistent with the grand mission envisioned by Reese, or the concept of community espoused by Norma?

Is there any antidote to the self-interest seen in Washington?

Is what we’re like at our best embedded in this world of unease and discomfort?

These are the new realities. How did we get here?

HOW DID WE GET HERE? A short history of the academic health center from a financial perspective

Most analysts would agree that there are two seminal events which set our educational and research missions. The first was the Flexner Report in 1910, and the second was the expansion of the National Institutes of Health in the 1940's. Both can be viewed as responses to external forces which brought with them opportunities for funding. In both cases, academic health centers readily accepted the funding and it changed the way we do things.

Flexner Report. In 1908, the Carnegie Foundation funded a study on the state of U.S. medical schools and hired Abraham Flexner to write the report. He visited more than 150 medical schools and concluded that overall many were inadequate and that several should be shut down. He suggested several reforms, including affiliation of all medical schools with universities (most were freestanding and proprietary), better science instruction, and paid clinical teachers (at the time, most clinical instruction was limited to following physicians around). Johns Hopkins was cited as an outstanding school, and immediately Johns Hopkins became the model for all medical schools.⁵

Interestingly, Carnegie himself did not believe that medical schools should be the object of his bounty, and the Carnegie Foundation refused to follow up with funding. Said Carnegie to Flexner, "You have proved that medical education is a business. I will not endow any other man's business."⁶

However, the Rockefeller Foundation did provide funding. It offered grants to Washington University, Vanderbilt, Yale, and Chicago. Later the public institutions—Colorado, Oregon, Virginia, and Georgia—received funding.⁷

Expanded NIH Funding. In the 1940's, the United States greatly expanded the funding provided to the National Institutes of Health and established both its intramural and extramural branches. As a result, it provided the financial stimulus for the growth of the modern research academic health center, and in fact, a major source of funding for the modern research university. Very quickly, an academic health center's amount of NIH research funding became the coin of the realm, and the rankings of the top ten in NIH funding and in U.S. News & World Report are virtually the same, and have been for the last 20 years.⁸

Expansion of the clinical enterprise. We turn now to the clinical enterprise. The factors shaping it are at least four: (1) the establishment of Medicare and Medicaid in the 1960's, (2) the creation of new medical schools from 1965 to the 1980's, (3) the entry of "for-profits" into health care in the 1970's and forward, and (4) the change from "usual and customary" as a basis for payment to a negotiated price.

The effect of each factor is briefly this:

1. Medicare/Medicaid. The establishment of Medicare and Medicaid in the 1960's made a large new source of funding available for a large group of people previously uninsured. In short, it put money on the table.⁹

2. New medical schools. From 1965 to the 1980's, the federal government stimulated the creation of new medical schools, increasing their number from 88 to 126, and increasing the number of students from 7000/year to 15,000/year.¹⁰ Part of the government's reasoning was to increase the supply of physicians as a way to force competition and thus reduce the costs of healthcare. Retrospective analyses have suggested the opposite consequence occurred: The increased number of physicians actually created demand, and the costs of healthcare skyrocketed.

3. The entry of the "for-profits." The for-profits, and corporate America, saw an opportunity. There were an increased number of physicians, a growing and aging population, and few controls on health care expenditures. After all, one was paid "usual and customary" or "cost plus"—that is, one's "cost" (as determined by the provider) plus a profit.

The for-profits also saw what they must have viewed as a group of amateurs going about the business of health care. Community hospitals were governed by well-meaning citizens with little or no background in healthcare delivery or finance. Physicians were largely organized—or disorganized, as the case may be—in cottage industries. There were no penalties for inefficiencies. All were absorbed into the "usual and customary" charges or "cost-plus" formulae.

The for-profits introduced established business practices into medicine for the purpose of making a profit. Humana and Columbia-HCA are good examples.¹¹ Humana began as a nursing home company in 1961

and then in 1972 moved into purchasing hospitals. It became a Wall Street favorite as it fast-tracked hospital construction. Between 1968 and 1980, Humana's revenues increased from \$ 4.8 million to \$ 1.4 billion.¹²

In 1990, Humana moved into a health consumers company and in 1993 spun off its hospital corporation to Columbia-HCA. Columbia-HCA was very aggressive. It built and bought up some community hospitals, keeping some open and closing others as inefficient. It grew to a mighty empire of over 350 hospitals.¹³ It introduced central management and back office functions. It created large and simplified supply chains and negotiated discounts because of its large market share. Its strategy in buying, building and closing hospitals was aimed at moving that hospital chain into profitable zip codes—i.e. insured groups of people. In 2008, HCA revenues were \$28 billion, as were Humana's.¹⁴

However, there was public backlash, with *qui tam* suits, fines and penalties over alleged denial of coverage or overcharging. Perhaps most dramatic was the testimony before Congress of Linda Peeno, an employed Humana physician, on denying a patient a heart transplant:

“I wish to begin by making a public confession: In the spring of 1987, as a physician, I caused the death of a man. Although this was known by many people, I have not been taken before any court of law or called into account for this in any public forum. In fact, just the opposite occurred: I was ‘rewarded’ for this. It brought me an improved reputation in my job, and contributed to my advancement...”¹⁵

In 2003, HCA paid the US Government, \$1.7 billion in civil and criminal settlements.¹⁶

To my mind, the for-profits forever changed the practice of medicine. They ended any serious discussion of whether healthcare was a commodity. Clearly it could be practiced as a commodity, and clearly it could be organized to yield a large profit.

There were social costs, however. Their zip code strategy led to a litany of new terms: “cherry picking”—the practice of picking off those with insurance, and “adverse selection”—the practice of leaving behind those without insurance (or covered by Medicaid, since it paid below cost).¹⁷

The closure of rural hospitals for non-profitability left devastated communities that often failed economically. Whereas previously such practices engendered guilt and musing over whether medicine was a calling or a business, they now became legitimized as prudent business practices.

The lesson learned was that segregating out well paying activities by either zip code or by procedures led to great profit. Individual physicians could organize their lives to become wealthy, as for example, cardiac surgeons in the eighties. This was the time that lower paid specialists without procedures could supplement their income with a profitable commodity. This was the time that family practice physicians began doing drug trials and psychiatrists began giving drug talks and developing consultantships with the pharmaceutical industry.

During this time, academic health centers were growing clinical programs and adding large numbers of physicians. Ludmerer, in his book, Time To Heal, commented that faculty grew in number as “if it were their birthright.”¹⁸ However, things were about to change.

4. The change from “usual and customary” to a negotiated price. We’re at about 1990 now, and once again healthcare costs are skyrocketing. Now employers were complaining, led by the automakers in Detroit who pointed to the costs they must pay to provide employee health coverage compared to Japanese automakers. Other employers wanted relief as well. Whereas the government responded in the 70’s, this time the insurance companies responded.

The first series of efforts were collectively called managed care. They involved various attempts at limiting access to services: closed panel HMO’s, prior approvals, the primary care physician as gatekeeper, financial incentives to physicians to limit care, and limitations on benefits, e.g. number of days in the hospital. These efforts failed because Americans rebelled. They complained about not seeing their specialist; few primary care physicians took the chance of losing a patient and so they simply referred them; legislatures began to write laws to expand coverage—e.g. to expand the number of days in the hospital after delivery, or to permit patients to see a specialist directly. While Group Health and Kaiser have become model HMO’s, most other HMO’s failed or were drastically decreased in size. What we see here is what happens to attempts to limit benefits. They conflict with America’s cultural norms and thus fail.

What did work from the managed care era was the transition from “usual and customary” or cost-plus payment to negotiated pricing exclusively. In the course of attempting to limit access, insurance companies developed closed panels and preferred provider organizations. In effect, this began the trend to negotiate directly with physicians and hospitals and thus create a provider network. You were paid whatever you could negotiate, not what it cost you to provide services, and thus competition for market share became the coin of the realm: The larger your market share the greater your clout. So for providers, the larger their share of the market, the greater the leverage they could bring to the table. For insurers also, the greater the number of providers they could bring to the table, the more attractive they were to customers.

This spawned dramatic changes in all hospitals but none more so than the academic health center. For the first time, attention was paid to amenities, like parking. We started collecting patient satisfaction scores and making changes in operations based on them. We started limiting waiting times, improving throughput, and creating efficiencies. We developed advertising and marketing budgets. We hired marketing firms to conduct focus groups, and we marketed ourselves accordingly.

We were adopting the for-profit methods, so successful in the 70’s and 80’s. While we didn’t abandon the uninsured, we marketed and built the more remunerative services—cardiology, sports medicine, imaging, etc. Next time you walk through RDU, count the number of hospitals claiming to have the area’s best heart center.

But by far, the most successful for-profit method was “horizontal integration,” or the acquisition of hospitals. We purchased Rex Hospital. In a word, we created market share. Some academic health centers created large primary care networks or feeder systems to increase market share. The more fortunate did not.

As academic health centers made changes to compete in this new reality, faculty feared we had lost our bearings and abandoned our mission.¹⁹ So let’s shift our focus to mission now and see how that plays out.

HISTORY OF WHAT WE DO BEST: The evolution of UNC's mission

To my mind, the singular defining characteristic of our school is its commitment to mission. The four year school was created as a response to state need. Our state had the highest number of recruits rejected from military service in World War II for medical reasons. As you all know the Good Health Movement that was mobilized in response resulted in the construction of North Carolina Memorial Hospital and the four year school. Thus from our earliest inception we were a value-driven institution “to serve the people of the state.”

When I arrived in 1997 – some 45 years after the opening of the hospital – I surveyed the faculty about what in their minds constituted the “model school.” They overwhelmingly chose “serving the people of the state.”

I must say I was astounded. I had spent my previous academic life at Duke and Emory, two fine private schools. Their faculties, if surveyed then, would have responded with something like “to advance our knowledge of disease” or “to create the next generation of leaders.” The scope would have been national if not global, and the focus would be to position themselves as number one. I suspect that’s true of most of our peer research institutions.

If you need further evidence of our unique commitment, just reflect for a moment on the chorus of complaints that erupted when the plaque which says “This hospital exists to serve the people of North Carolina” was not replaced immediately after construction of the new hospitals.

There is little question that our commitment to mission has been our guiding principle and our defining characteristic throughout our history. However, much uncertainty exists over how we meet that mission. I remain surprised that large swaths of our community – faculty, staff, alumni, others – interpret it narrowly as providing indigent or uncompensated care.

There is simply no reason to limit the meaning of serving the people of the state to providing indigent care. Our history does not support it, a sampling of legislators or legislation itself does not support it, nor does faculty effort support such a narrow definition.

Let's borrow the framework developed in the previous section on the history of academic health centers. We will look at our mission from 1952 to 1990, and then since 1990 and the managed care/negotiated fee era.

1952 to 1990: No question, providing indigent care was expected of us. Legislators expected it, referring physicians around the state expected it, and patients expected it; and faculty embraced it. And, without question, our educational mission was universally embraced: our school was to provide physicians to practice in our state.

However, our mission expanded. AHEC redefined our responsibilities to the state to include continuing education throughout the state, providing a workforce for the state, and providing specialty clinics throughout the state. Our mission was no longer limited to UNC hospitals or the medical school.

There is also historical evidence acknowledging the importance of our research mission for the people of the state and the role that technology development could mean for economic development. In 1959, university leaders were prime movers in the development of Research Triangle Park, an enterprise which is the envy of many other states to this day. To some outside the state, it is the defining characteristic of the state. It represents not only an acknowledgement that the university is vital to economic development, but also that the state is depending on us.

1990's and forward: So, even prior to the managed care/negotiated fee era, there were frequent updates to the mission of the School based on legislative intent and faculty consent. I believe the creation of the healthcare system in 1998 will become a seminal event in the history of the school, not because it changed the mission, but because it challenged the culture that existed here, and it reawakened the interest of the legislature in this place, resulting in a higher level of accountability and a spate of legislative financial support unprecedented here, or perhaps anywhere in the country.

So, why the healthcare system? In a word, to make us more competitive. The movement to a healthcare system began before my arrival. There was a general feeling that we were lagging our rivals in our response to "managed care." The legislature called for a study of the hospital and its readiness for the changes in health care in April of 1997, a month before I arrived. President Broad asked Larry Lewin, a widely respected consultant, to review the situation, and he concluded we were not prepared to compete

in the 1997 health care environment. He forecast a \$50M shortfall in two years if there were no changes. It was he who first recommended the two changes to make us more competitive.

The first change was to provide us with management flexibility by freeing us from the strictures of state government with regard to human resources, purchasing, construction and contracting. The second change involved the restructuring of governance so that a single CEO would have authority to make decisions.

The decision to grant us management flexibility was a big deal. Others within the UNC system have followed us and asked for it, only to be denied. That we were granted it underscores the legislature's understanding that we are different and that they wanted us to compete.

While our mission didn't change, how we were to go about it did. We were not going to be a completely subsidized government agency. We were not going to be an indigent care satellite to nearby private agencies. We were going to be a highly competitive health care system. The changes brought about by the creation of the health care system permitted us to initiate the same kinds of changes that other academic health centers were making. But the adaptations we made to become competitive resulted in changes viewed by many faculty as culturally dissonant and thus resisted.

Our culture was challenged. The increase in funds from Rockefeller and NIH, from Medicare and Medicaid and then private insurers didn't require a great adaptation on our part. They simply fueled our existing machinery. The changes wrought by competition, however, were dystonic to our culture in some ways and thus resulted in much unrest.

The first change involved the role of the faculty. Historically, being a faculty member meant being able to choose an area of inquiry and pursue it wherever it took you. And prior to 1990, with a surplus of money available, one could pretty easily shift between clinical duties and academic duties. Clinical responsibilities were not a hindrance; they were an add-on. Departments provided just enough services to support faculty financially. There was no need to provide 24/7 comprehensive services.

After the 1990's, faculty were hired for specific roles, thus narrowing their potential scope of academic inquiry, and 24/7 comprehensive coverage

required a much more exacting schedule for clinical services. All of this contributed to a loss of autonomy.

Some faculty were hired to provide clinical care only with little if any academic responsibility. This was decried by some faculty as a violation of the academy. Some questioned if we were returning to the proprietary age.²⁰

Second was a change in the relationship of the Chair and the Dean. Prior to the changes in 1990, the Chair was czar. If one was a surgery, or a medicine, or an anesthesiology chair, their idea of what constituted a first-rate department was a mental image constructed by them based on their knowledge of what other first-rate departments around the country consisted of. It would have x # of subspecialist programs, y # of research programs, and z # of clinical programs, a certain number of residents, and so forth. To the faculty member, the Chair was god, and the Dean was useful only as much as he provided dollars and stayed out of the operation. The practice plan was independent in that the Chair controlled the books.

As health systems were formed, Dean/CEO's emerged because departments needed to meet the needs of the health care system. The health care system determined, in the case of surgery, medicine or anesthesiology, for example, how many of each specialist was needed, the number of residents, and ultimately how much research could be funded. The Dean went from a provider of funds to a CEO who ultimately determined the nature of the department. The Chair went from czar to middle manager, needing to implement the needs of the health care system, while attempting to appear the czar to his or her faculty. The Dean/CEO emerged as the predominant power.

Third was the introduction of metrics to measure faculty activity. As Dean/CEO's searched for ways to run the ship, they began to use value metrics. "If you can't measure it, you can't manage it" became the law of the land. Quickly, clinical work units, time teaching, and research funding were quantified and eventually rolled into a compensation plan which satisfied few of the faculty. The transition from free-spirited artist to hired worker was completed.

Legislative interest was reawakened. The creation of the healthcare system also reawakened the interest of the legislature in this place, resulting

in (1) a higher level of accountability and (2) an increase in financial support.

Historically, this University sits at one end of the spectrum of legislatures' interest and involvement with the operations of their state universities. Some state schools prefer to have little to no involvement with the legislature and the interaction is minimal. UNC, on the other hand, has worked closely with the legislature and its priorities. Its leaders have encouraged involvement. Further, the media have reinforced this close involvement by demanding transparency.

In addition to this historic position, I think that the creation of the healthcare system, with its management flexibility, reawakened interest in this place. And the funding of the cancer hospital reiterated that interest. Permit me to divert and tell a short anecdote with regard to the funding of the cancer hospital, which illustrates our legislature's view of this place.

It was late in the legislative session, and Senator Basnight called me and asked me to come down and meet with the leadership group—all committee chairs in the Senate and selected high-ranking members in the House—in short, a group that could make something happen or not. It was the end of the day, they were all busy, and here was Jeff Houpt, asking for \$180 million—at the end of the legislative session, no less. I began talking, and as I scanned the room, I was unable to tell if I was making contact or not. I finished by asking for questions, and they were mostly of a factual nature, but I sensed no groundswell of support for throwing in \$180 million at the last minute. Then, one of the members present asked the group, “How many of you have been treated in that hospital [Gravely], either yourself or a loved one?” At least $\frac{2}{3}$ to $\frac{3}{4}$ of those in the room raised their hands. There followed a quick consensus that the doctors and nurses were great but the building was an embarrassment. I knew I had a foot in the door.

The conversation shifted to “Yeah, but if we fund it, it's just one more thing for Chapel Hill. What about the rest of the state?” The rich get richer, etc. My protestation that “Yes, but we treat people from every county of the state” blunted the rebellion but by no means quelled it. Then I believe it was Tony Rand who said, in his loud baritone voice: “Gentlemen, this isn't the good doctor's hospital; this is OUR hospital. We own it. It's ours. We're the ones responsible if it's in

deplorable shape. Whether it's in Chapel Hill or not is irrelevant.” Fundamentally, the deal was done—although funding occurred a year later.

However, with increasing largesse comes greater scrutiny. Most of it continues to be impressionistic, but remember, most of the evaluators—the legislators themselves—use this hospital. How clean are the rooms? How long did I wait in the emergency room? Did my doctor see me each day or did he or she send a resident? After all, this is OUR hospital—or, if you're here as a patient, this is MY hospital. I own it, I fund it. You'd better do it right. Do I need to go to Mayo or Hopkins or can I get the best here?

In recent years, impressionistic scrutiny has given way to published measures of quality. As more and more publications rank hospitals, and public discourse is directed to quality, or lack of it; as insurance companies start Zagat guides; as internet sites provide an increasing array of statistics on mortality and outcomes – we become subject to all of that. In exchange for funding, we're expected to not only be the best but to be ranked the best.

This is a major shift. Until the era of competition and the creation of the healthcare system, we were expected to provide care – if we provided access to legislators' constituents we had done our job. Now, we are expected to lead our competitors in quality, access, and amenities, and we are to remain financially competitive. Said more starkly: Before, our mission was simply to serve the people of the state. Now our mission is to remain financially stable while providing first-rate amenities as well as access and quality.

The increased involvement of the legislature has also stimulated a spate of legislative financial support unprecedented here, or perhaps anywhere in the country. Consider the legislature's actions since the creation of the healthcare system:

- bond issue for renovation of buildings: \$73 million
- cancer hospital: \$206 million
- University Research Fund: \$50 million/year
- new imaging research building: \$242 million

Before we leave the discussion of mission, we need to at least comment on the renewed interest of the legislature in our research programs. The recession of 2002, which now seems small considering our current situation, redirected the legislature to our burgeoning research activities. That along with what we now call “pizzagate.”

In 2002, some members of the legislature decided that they would attempt to take back a percentage of the indirects that were being returned to the campus. The pretext for this was our misuse of indirects—namely the purchase of not just pizza but gourmet pizza—for graduate student seminars. Chancellor Moeser, Vice-Chancellor Waldrop and I were called down there to defend our use of the monies on the premise that if pizza was our best use of the funds then we certainly did not need them. The unintended consequence of this was that it became apparent to some legislators how robust our research activity had become and reawakened the notion that our research was indeed an economic engine that needed to be encouraged and not throttled. Just how much this played into the funding for the University Research Fund or the imaging building I do not know. What I do know is that “pizzagate” did put discussion about research back into legislative discussion, extending beyond its previous focus on the clinical enterprise alone.

In the end, these past twelve years, beginning with legislation to create the healthcare system, then greater legislative interest in us, and then this remarkable spate of funding, has led to a new statement of purpose: to be the best. And interestingly, the legislators might have done a better job than us in defining what they mean by the “best.” Beginning with clinical care it means never needing to leave the state for care, and it extends to research and education “as good as anywhere.”

OUR SENSE OF COMMUNITY OVER TIME

If you ask faculty what is most characteristic of us you would probably hear, “It’s our collegiality.” It is immediately apparent to any visitor to the campus. It was immediately apparent to me when I interviewed to be your dean, and I found it immediately apparent to the faculty we recruit.

I attribute this to the woman we honor today, Norma Berryhill. All of us who knew her learned of her interest in entertaining the faculty at their home and her interest in keeping a friendly relationship among faculty and between administrators and faculty. The first time I met her, she chided me for living in Governors Club: “You should have bought a house on Franklin Street,” she said. As I listened more I realized she really didn’t care where I lived, she just wanted me to uphold the tradition of being open and accessible to the faculty.

Things have changed since her time as First Lady. The faculty now numbers 1600, and the kind of intimacy that permitted the Berryhills to get all of the faculty in their home can never exist.

But the characteristics of our behavior, which we describe as collegial, have become the norm. If I had to point to the most concrete manifestation of this collegiality, I’d point to the success of our centers and institutes. When the AAMC looks to a place to study where centers thrive, they come to UNC. Not only on our campus but across the entire university, some of our most nationally recognized academic endeavors are located in our centers.

Second, there’s a greater inclination here to try to solve problems by enlarging the pie rather than by hoarding and protecting resources. Students of negotiation will tell you that there are two approaches to negotiation. The first is to assume a “position” (positional negotiation) and hold to it, refusing to budge or compromise, and in the end, winning the best deal possible. Think buying a car.

A second approach tries to look at the underlying interests and find a solution which accommodates both parties (issue-oriented negotiation). Here the common solution requires enlarging the pie—both parties contributing, or finding a third party to also contribute and participate. UNC is expert at this approach. It’s what we do when we are at our best.

We are also at our best when we work cross campus to solve problems. What I find most gratifying is when I see evidence of South Building working on our problems, or faculty from other colleges like Arts and Sciences working with us and vice versa. The Carolina Center for Genome Sciences is a prime example.

Our collegiality becomes a self-fulfilling prophecy. Faculty choose to come here because they sense they can work between disciplines here, that there are no fiefdoms. And so those who select to come here are already wired to behave in that fashion. They then set the stage for continued recruitment of like-minded individuals and reinforce and strengthen our sense of collegiality.

However, our collegiality has a downside. In my opinion, it sometimes leads to our supporting mediocrity. We shun internal conflict and we thus avoid confronting either people or parts of our administrative apparatus when confrontation is necessary. We sometimes choose collegiality over professionalism or excellence. We are too willing to accept the status quo and just let things ride. This is not when we are at our best. We are at our best when we are talking about science or planning clinical programs and rooting out obstacles, not permitting ourselves to avoid the best way because of perceived obstacles. Pursuing excellence, and eliminating mediocrity, must be our driving force. It's the only way to be at our best.

THE IMPLICATIONS OF TODAY'S REALITIES

If we return now to the first set of characters, you will see that they can be organized into two groups: those who are part of the clinical enterprise – the Gregantis, Petersons, Parks, Meyers and Cairnses – and those on the research/translational side – the Bouchers, Buses and Pisanos. I would argue that all of these interactions are efforts to meet mission, even though they are viewed by some as being only about money.

Let's take the questions of relationship with industry and conflicts of interest first. I believe strongly that technology transfer and economic development are important functions for us. They certainly have been emphasized by our last three chancellors, and by our university leaders back as far as the development of Research Triangle Park. With the loss of tobacco and the furniture industry and the current realignment of banking, science and technology are our best candidates to drive the new economy. The state is depending on us. This is our mission as much as caring for indigent patients.

At the same time, we must admit that recent disclosures about the sums of money that industry has set aside for academic leaders, whether as

consultantships, medical directorships, Board positions, or speakers bureaus, or in support of individual research, have damaged the public trust. Steps must be taken to restore that trust. Disclosure and management of these issues is essential.

But I fear “throwing the baby out with the bathwater.” An easy solution is to create administrative bottlenecks and thus choke off the interaction of industry and academia. This is a time, I believe, to continue to experiment and attempt to manage, even if it means making mistakes, rather than prohibiting the interaction. The public interest is best served by the creation of new products and by the application of ideas conceived in the university and brought to market by industry.

Now to the questions raised by the clinical leaders. I believe these vignettes are about meeting mission as well as money issues. I also believe they can be viewed as sources of personal and interpersonal anxiety. One can view the anxiety as the result of an interest in meeting mission in our current commoditized environment. In working with faculty I have come up with only two approaches to this problem. I offer them to you. They are: (1) Determine what is normal background noise and what needs an intervention; and (2) for anxiety and stress utilize multiple reward systems.

I must confess that as a Dean one of my biggest problems was distinguishing what I would call necessary and acceptable background noise when thinking of faculty complaining of their lives versus a situation that needed to be addressed. Part of my thinking resulted from my own experience as a clinician scholar, whose only “release time” had to be grant-supported and where as a psychiatric consultant to the medical floors I had to be available 24/7. I know the pressures of managing clinical responsibility and an academic career. I also know that making that work requires flexibility from your boss. But it also requires his ignoring your complaints at times. I had a great boss in Keith Brodie at Duke. He gave me a great deal of flexibility with regard to managing my time, but he also knew when to tell me to stick to my knitting. One of his best interventions was when, after I had complained about something he decided to do that I felt disadvantaged me, he told me that he’d take care of policy and that I should go back to teaching, research, and patient care. When to tell faculty to stick to their knitting and when to respond with an institutional response was always a hard decision. I know I didn’t get it perfectly right.

On the other hand, my observation is that today's times are different, at least in degree. Just one irritant as an example—the requirements for documentation to insurance companies or federal agencies. They have taken over and reshaped how we teach and how we provide care. This is another case of the tail wagging the dog, and it's not a good outcome. I was told the other day of a patient who went to see her doctor and he sat with his back to her recording what she said into his computer while taking a history. There has to be limit to this. If we can't get this corrected locally, perhaps in health care reform we can start with good patient care and build our documentation systems around that. The creation of a real easy-to-use health information system can reduce onerous duplications and actually improve and speed up patient care.

The second point has to do with using multiple reward systems. I am amazed that financial incentives are used almost exclusively to “turn the ship”. People are motivated by much more than money. Can I eke out a career here? Can I have a family and meet certain lifestyle desires here? These issues of anxiety are not always or even mostly about money. We need to create broader reward systems.

As I was preparing my talk I asked Dr. Greganti when he called me one night at 9:30 how he coped. He said, “Well, I love working with the people, and when you get right down to it, it's a privilege to be a doctor.”

CONCLUSION

So let's now pull all of these analyses together and examine the fit between our historic commitment to mission and community against today's realities.

I have often been asked by trustees and others since I stepped down, “What does UNC need to do to become an even greater institution?” My reply is always: First of all, don't lose what makes you great now. You have a culture that puts others' interests above one's own. This is seen in the commitment to serve the people of the state and a sense of collegiality here that enjoys and celebrates the accomplishments of others.

I know this is considered soft stuff but you can't buy it, and to build it into some other prestigious institutions would be nigh impossible. Don't ever underestimate its importance.

Consider for a moment our President Barack Obama. Imagine his meetings with AHIP, AMA, and the pharmaceutical industry. Each is committed to protecting their constituents, by protecting their bottom line. Imagine if he entered a room with them, they sat down together, and they all had the public interest at heart. That they actually pooled their talents and their lobbying capacity to find the best solution for the public and began by asking this simple question: What is in the public interest? He'd be halfway home.

In contrast, we are always halfway home. What an advantage! We begin with a commitment to the public good. It permeates our institution. An institution's commitment to the public good is not a subtle distinction. It stands directly opposite a position of self-interest or self-aggrandizement.

I asked Gene Orringer to read this presentation last week to critique it. He asked among other questions whether I believed that institutions had personalities, and if so, were they fragile. I'll end by coming at that question a different way. I believe institutions have a character or culture—a very distinct set of values that shape the way people behave. That over time people buy into it and feel comfortable and anxiety-free when they behave according to the rules. When those norms are violated people recoil.

John Gardner, in his book On Leadership, has argued that values naturally decay over time and that they need to be revitalized.²¹

Values always decay over time. Societies that keep their values alive do so not by escaping the process of decay but by powerful processes of regeneration. Each generation must rediscover the living elements in its own tradition and adapt to present realities.

Unfortunately he does not tell us how to do that. In the leadership course I now teach, I ask the faculty attendees how to do it. After listening to their responses, and pondering on my own, I have come up with only one simple way: SAY IT!

For example, when the chair is introducing the compensation plan: “This is how I got to this. I had to take into account indigent care. I had to take into account our teaching responsibilities, our department’s goal for research. Now if we can reaffirm these goals, let’s work out the details.”

Don’t ever underestimate the power of speaking up. Most books on leadership talk of the need for the leader to reaffirm values and to speak up when someone or some external event threatens them. That’s true. But my observation of academia is that it is also the responsibility of the faculty and the larger community. If the legislators feel that they own the hospital, then it’s the faculty who own this culture. This is your school. If you like these values of commitment and service to others, make it your responsibility to see that they are reaffirmed. Simple words like “I don’t know if we should do that because I don’t see that it’s on mission.” Or “I know its going to be hard on us but I think it serves the greater good. I’m with you.”

We may live in a highly commoditized medical market place. The antidote is to have an orientation that insists on finding the public good. We may live in a world of self-interest. The antidote is to live in a culture that celebrates others doing well. UNC has had these from its beginning.

So, to answer the question where we started: “Is our commitment to serve the state and our sense of community relevant in today’s reality?” YOU BET! In fact, they’re essential—more so today than ever. If we continue our commitment to mission we will always have purpose. And our commitment to community will offer new opportunities and make us happy as we do it.

¹Kassirer, Jerome, On the Take. New York: Oxford Press, 2005.

²Harris, Gardiner, “Top Psychiatrist Didn’t Report Drug Makers’ Pay,” New York Times, October 4, 2008.

³ Pear, Robert, “Health Proposal in Senate Panel Pays Its Way With a Fee on Insurance Companies,” New York Times, September 7, 2009.

⁴ Sack, Kevin and Herszenhorn, David, “Texas Hospital Flexing Muscles in Health Fight,” New York Times, July 30, 2009.

⁵ Flexner, Abraham, “Medical Education in the United States and Canada,” Carnegie Foundation for Higher Education, 1910.

⁶ <http://pubpol.duke.edu/flexnew-report>.

⁷ Ibid.

⁸ <http://grad-schools.usnews.rankingsandreview>

⁹ Ludmerer, Kenneth, Time to Heal, p. 233. New York: Oxford University Press, 1999.

¹⁰ Starr, Paul, The Social Transformation of American Medicine, p. 421. New York: Basic Books, Inc., 1982.

¹¹ See Wikipedia/Humana or Hospital Corporation of America

¹² Starr, op.cit.

¹³ uow.edu.au/Columbia

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- ¹⁴ See Wikipedia/Humana or Hospital Corporation of America
¹⁵ en.wikipedia.org/Humana
¹⁶ Ibid.
¹⁷ Starr, op.cit., p.436.
¹⁸ Ludmerer, op.cit., p. 371.
¹⁹ Ludmerer, op.cit, pp. 370-399.
²⁰ Ludmerer, op.cit., pp. 370-399.
²¹ Gardner, John, On Leadership, p. 13. New York: Free Press, 1990.