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Interviewer: **Karen Thomas**
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Thomas: Dr. Scherger, I just wanted you to discuss or outline for me how you became interested in meeting the needs of medically underserved populations, and you have certainly been a leader in family practice medicine and various other aspects of medical leadership that contributed to your being chosen as the Dean of the College of Medicine at FSU, and I was just wondering if you could give us come background on those qualifications?

Scherger: Well, thank you, Karen. I'm happy to. I've had a mission to serve underserved populations or people of need my whole life. I grew up in a small town in Ohio and my parents instilled a very strong service ethic with me. I remember my uncle, a general practitioner who delivered me, once told me that the most appreciative patients and the patients you're going to enjoy caring for the most will be the low income patients. And that always stuck with me. As a medical student, I volunteered in a community clinic in Venice; I was at UCLA and really found that satisfying. In my residency, I did the same and really enjoyed serving underserved populations. And that led me to be a volunteer in the National Health Service Corps, where doctors are placed in areas of need. That's what brought me to Dixon, California, where I served as family physician for fourteen years. The Kellogg National Fellowship Program, which I started in 1988 while I was in Dixon, has prepared me for broader health policy and broader leadership, but still a focus on meeting community and society's needs.

I then went on into a more academic career starting in 1992, where I became a residency director at Sharp HealthCare in San Diego and then a department chair of family medicine at the University of California, Irvine. That was for five years, 1996 to 2001, the job I had just before coming to Florida State. And while there, I worked very closely with community clinics which we served as part of our department Latino health access led by America Bracho right there in Santa Anna, and built some educational bridges there. So my background, rural diversity, primary care, serving underserved populations – these were all the core missions of the new medical school.

Thomas: To back up a bit, when you were in the National Health Service Corps in Dixon, California – that was a rural area of northern California. Tell me about the type of populations that were served in that area and what kind of health problems they faced.

Scherger: Well, the population that would be very similar to north or central Florida – it was an agricultural population. In California, it was more of a Mexican-American immigration, although that's quite common in Florida, too. You have other Latino immigrations. But my

limited Spanish became very, very important and useful. But also the white farming longstanding population of Dixon I cared for. We were the only doctor's office in town, a town of about 6,000 people. So we saw cradle to grave. But primarily either a Latino or Caucasian ethnic group; very few African Americans in a rural northern California town.

Thomas: And so you were very involved in migrant health issues and you were also serving as regional director of a network of rural health clinics – is that correct?

Scherger: Yes. It was a small network. We had three clinics that I was a co-medical director of with my partner, and we rotated among those three clinics. We had nurse practitioners working with us. And yes, that was a rewarding part of the work I was doing then.

Thomas: Right. What relationships did you or the people that you were working with there have with either local, state, or the federal government?

Scherger: Well, we were part of a federally qualified community healthcare system. So I became familiar with the community clinic system both in California and nationally. The National Health Service Corps is a national program and graduates of that were invited to join an organization called the Association of Clinicians for the Underserved, or ACU, and I'm a charter member of that organization and have spoken at a couple of their functions.

Thomas: And about when did that organization start?

Scherger: Gosh, I would be guessing, but I believe it was in the early 1990s.

Thomas: Okay. So clearly you were in a key position to understand the needs of medically underserved populations, and that was certainly a piece of the mission of the FSU College of Medicine. Can you talk about how you translated that background both from northern California and other parts of your experience – what were your goals and what were your obstacles when you came to FSU with the issue of medically underserved populations?

Scherger: Well, the goals were already in place – to address Florida's underserved populations. I was able to start with the goals that were already there. I mean, it's very difficult for a new person from the outside to come in and change the culture. And fortunately, the PIMS program that was in place, and Myra Hurt, the acting dean, had already established admission policies to look for diversity and look for commitment to service to underserved populations. So I was very fortunate to walk into a situation that those values were already there. They weren't fully actualized, but there was no need to change the goals and mission of the school, only to articulate those goals better and to really actualize those goals in a modern medical environment. I think in Tallahassee it was pretty easy, given the nature of Tallahassee and its liberal-mindedness, if you will, and its number of community health centers, et cetera. And when we reached out to our other community sites – Pensacola and Orlando – some of that commitment

was there, but there was always this lure to high tech modern medicine for the students and for the school. So it was going to become apparent that we had to somehow balance this service mission to the underserved with the kind of lure of high tech speciality medicine which flourishes among people who are well insured.

Thomas: I wanted to ask you about another piece of the mission at FSU, which was to encourage the training of primary care health professionals. You said that in San Diego, when you were in the leadership of the Sharp HealthCare System, you were the founding director of a program to train family doctors and you had also talked in a previous conversation about wanting to pursue leadership in medical education and then you went on to become chair of family medicine at U.C. Irvine. So could you talk about what your experience already was in family practice and your leadership in that area, and then again relate that to FSU?

Scherger: Sure. I became very committed to primary care and family medicine during medical school in the early '70s. I decided that I wanted to be on the front line of medicine. The idea of being able to be the doctor of any member of the community was very appealing. And so to have that breadth of training and to be on the front lines of the community based physician was something that I think was incredibly exciting and incredibly important. And it's been well shown by Barbara Starfield at Johns Hopkins School of Public Health and many others, is that the foundation of any healthcare system in any country of the world is its primary care. Now, America loves its speciality care and high tech medicine. America is one of the lesser countries in the world that has a healthy respect in promoting primary care. And while most other countries in the world have at least 50% or more of their doctors in primary care, in the United States it's less than 30% and shrinking. Now, you know, primary care had an upswing in the early and mid-'90s with the development of managed health care, when it was found the health care would be more efficient and less costly if everyone got their care by and through a family doctor. With the collapse of managed care, and people rebelling against it, wanting open choice to specialists, there's been an erosion in primary care since the late '90s and through most of this decade. But at the time the Florida State school was being envisioned and developed in the late '90s, it was very clear that Florida needed more primary care, especially in the smaller communities and the rural areas and for the diversity of populations. So the commitment of the Florida State medical school, the primary care, really matched the imbalance of physician professionals in Florida and the community needs.

Thomas: One of the things that I'm particularly interested in, and what you've just touched on, is the relationship between public policy and trying to serve the needs of all of the citizens of Florida, for instance, and getting medical schools to participate in and even lead in the area, and I think that, you know, FSU was — the legislation that created the FSU College of Medicine gave these mandates to improve primary care, improve the distribution of physicians, meet the needs of medically underserved populations. And that was all right there in the founding legislation. What do you see as — and of course, that has been often difficult to actually carry out in practice in an academic medical center. How do you think that FSU tried to be different and tried to

really be faithful to those principles, and can you also possibly compare FSU to some other institutions who have also tried to carry out that kind of public mandate?

Scherger: Sure. Well, there's two parts to getting success and having your graduates be consistent with the mission of the school. The first part is the right admission policy. It's been known for along time, for example, that if you want doctors to go to small towns, you're way more likely to have them do that if they come from small towns. So they should resemble coming in to some degree the social background that you'd like going out. And that means that sometimes you accept someone with a lower grade point average and maybe a little bit lower medical college admission test score, but because of their social demographic factors, they're more consistent with your mission. But you know, medical schools often pride themselves on how high their average GPA and MCAT scores are. So you got to be willing to kind of put aside that ego to fit your mission. But then the second part is their experience during medical school, and what FSU did – and I give a lot of credit to Ocie Harris, who was associate dean while I was there and was there before I came, and Myra Hurt – they were very focused on keeping the students in the community and serving the population while they were training rather than spending the vast majority of their time in the high tech hospital. When students are in the high tech hospital and they meet all these specialists and they see the exciting work that they do, and they spend very little time grounded in the primary care environment and community, they all drift off into radiology careers and anesthesia careers and various sub-specialty careers because that's who their mentors and role models predominantly are. And so its very important to give the student enough of that for training, but to keep them grounded, keep them in touch with the inspiration, the service, and the commitment to serving the others. Now many medical schools have stayed somewhat aloof from a real meeting social need mission, other than to produce outstanding medical scientists for America and the world. And the notion of somehow you're supposed to train doctors to meet the most important needs of your immediate community conflicts with the academic freedom and the sense of being a medical school of major reputation for excellence and high tech modern medicine. And so schools often get lost in being in touch with the state's needs. The state legislature and the leadership at Florida State have been determined to not follow the traditional path and stay committed and to create programs that would result in that.

Thomas: In talking with some of the other people such as Myra Hurt and state senator Durrell Peaden, for instance, they have really stressed both the revolutionary nature of this distributed model without a central teaching hospital, which you just referred to, and also that that was a much more expensive and inefficient model of medical education, to have that hospital, and also that FSU does not have a practice plan, so it's not relying on a lot of clinical revenues for its ongoing budget, which is the case with many other medical schools in the US. Could you comment, you know, on those differences between FSU and the traditional model of medical education?

Scherger: Well, it's very different. In the traditional model, especially with the money that

was available after World War II and especially in the 1970s, medical schools had these large academic health centers and faculty practice plans which were really a major source of revenue. And the budgets of the medical schools would be by today's dollars 800 million to over a billion. I remember when the dean at University of Miami said, "Well, my academic health center budget is a billion dollars and my medical school budget is 800 million dollars. The budget of Florida State's medical school at maturity would be about 40 million dollars. Extremely small in comparison. But because of that drastic imbalance, the dean and the other leadership of the medical school spend the vast majority of their time dealing with the economic business issues of maintaining this very large medical enterprise. And the education of the students is almost a byproduct, and it's very, very small – in a dollars point of view – much less important part of the whole medical school. It's so different, and what makes Florida State — it's not 100% unique, but it's rare. As a matter of fact, to my knowledge the only other medical school without a faculty practice plan in the United States is in northeast Ohio, and has a budget very similar to FSU. FSU was modeled after the Michigan State model, which is very accurate in many ways. But even Michigan State had a Lansing, Michigan, based faculty practice plan within its midst. It didn't have a specific academic hospital, but it did have the practice plan. So these are very rare. But it does mean that you're more dependent on state revenues, you're more dependent on the political process to keep it funded and keep it focused. But it also lets the leadership focus on education and the product of the medical school per se as opposed to being so consumed by running a hospital and a faculty practice.

Thomas: I think that the line of discussion we've just had relates to one of — you gave me a list of five accomplishments or contributions during the time you were dean, and one of them you said was changing the original plans for the College of Medicine main building from 2/3s space for wet labs for research to 2/3s space devoted to education, including a dry lab for social science research. So that reflects that shift away from the traditional medical school emphasis on research in basic sciences particularly, and then moving toward focusing on education. Could you talk more about the way that education of medical students at FSU differs and how you helped shape that?

Scherger: Well, yes. What automatically happens whenever there's a university with biology departments and chemistry departments, when the idea of a medical school comes, they immediately see, "Oh, boy! Our research programs are greatly enlarged; we're going to get NIH grants; this is just going to be tremendous!" And it is. And that's fine. But that is kind of like the university's first response is that they see the tremendous opportunity of expanding their current research programs. And certainly the college of medicine did that. But when I came, I felt that that was way out of balance with the core mission of the school. And so without giving up that opportunity, we just simply put it in perspective and expanded the predominant space and nature of the faculty leadership to be very consistent with the actual mission of the school, which is not biomedical wet lab research, but students who would understand the needs of society and the healthcare priorities and be really the most talented in being community-based physicians. I don't think there's another medical school in the country that has a curriculum and a space that is

so devoted to not just the biological science of medicine but the social science of medicine, the prominence of the department of medical humanities and social sciences, the prominence of the department of geriatrics, and their relative size would be extraordinary compared to any other medical school in the country.

Thomas: Right. And another one of those contributions you mentioned was that you advocated expanding the number of departments from three departments originally to five, adding a department of geriatrics, which it's very rare to have a full department devoted to geriatrics, and then having also a full department of medical humanities and social sciences. What do you think those two departments will contribute to the mission of FSU's College of Medicine?

Scherger: Well, the five departments, as you see them there, are a beautiful representation of the core missions of the school – geriatrics, serving underserved populations, and rural medicine – humanistic physicians – all these things right in the law. I should say that pretty much all medical schools in the country have close to twenty and sometimes maybe even more than thirty departments. And it's been commented on that the departmental structure is one of the problems of traditional medical schools, because faculty become so loyal to the pyramid or silo of their own department. So a non-departmental type structure was very much a part of the thinking of forming Florida State, and let's just keep it really simple and put all of the basic sciences in one department and all of the clinicians in another department. But because family medicine's so important, we'll give them their department. And those were how the first three were thought of; it was sort of a non-departmental but let's at least have the bare minimum. And I liked the non-departmental concept and the avoidance of silos and pyramids, but as I looked at it, what was missing was where's the focus on geriatrics and where's the focus on medical humanities and how do we balance the biomedical sciences with the social sciences. So we met in a retreat environment and realized that we would still be consistent with a common community, non-departmental structure, but we'd be in better balance if we had the five departments instead of three.

Thomas: Not only were you one of the people who wanted to add a rural health piece to the family medicine department, you also helped set up the public health division under Robert Brooks. Could you talk about the relationship between — I mean, the spheres of public health and medicine, you know, in the late 20th and early 21st centuries had become very separated, and it seems that FSU's vision is to make public health a more integral part of medical training and practice. How did you envision that and can you also tell me something about Robert Brooks and his leadership?

Scherger: Well, sure. First, my own master's degree in public health from the University of Washington, where the School of Public Health and the School of Medicine were in the same building complex – I also had that same at UCLA – gave me a grounding and some pretty good integration and benefit of the two being close together so that public health people look at

populations, medical doctors look at patients. But if you've got you know, public health people that look at populations understand the situation with individual patients and people who take care of patients realize the bigger picture public health, we're way better off. Florida State doesn't have a school of public health; it does have the School of Social Sciences with a lot of public health interests. But what was really very exciting to jump start this was Robert Brooks, who had been the public health officer for the state of Florida, and was on the founding selection committee with the medical school. And the dean came to me and was very interested in having a leadership role in the medical school. So this was an instant opportunity. I mean, he was such an ideal person with his practical experience and his academic interests; he was just a natural to lead the development of a public health division with the medical school, which is kind of an extra opportunity when the medical school isn't competing with or having a separate school of public health.

Thomas: Obviously you helped recruit Robert Brooks and you said that the other faculty members that you were particularly proud of recruiting were David Steele, Nancy Clark, and Ken Brummel-Smith in addition to Robert Brooks. Could you talk about faculty recruitment, and you know, that must have been very challenging in a brand new medical school, but what was the philosophy of faculty recruitment at FSU and how did you participate in that?

Scherger: Well, as a dean, I thought it was in many ways my most important job, or it was right up there as one of the top priorities, was to build the school with the right people. As the first new medical school in twenty years, it was not hard to find innovators, and then you had to find the innovators who were consistent with the mission of the school. Medical education, amazingly, feels like a second class citizen within most medical schools, because almost all the budget deals with clinical programs. And so to come to a medical school where medical education was front and center, and not only just to train excellent doctors but for good, right, needed social purposes, was really a good selling point. We had lots of people send us CVs and letters of interest. We wanted to then go find the best people. And so we made phone calls to key places like the AAMC in Washington and the Council on Medical Education of the AMA, and we actually went out and grabbed people that weren't even looking for jobs. For example, Dave Steele was very happy where he was at, but his name kept coming up as an ideal person. So we went after him and convinced him that this was a chance of a lifetime to come here and lead. We were going to be the first new medical school in the information age, and we had this opportunity of being right out of the chute a very information technology rich school. I happened to know that Nancy Clark was a super star IT educator for students and doctors. And so I went after Nancy; plucked her from South Alabama. She wasn't necessarily looking for a job, but we just gave her an offer she couldn't refuse and got her here. It was really fun for geriatrics. Florida State is one of five medical schools in the country out of 127 that has a full department of geriatrics. But we wanted the best. And so I went to the American Geriatric Society meeting. I started narrowing the list of people I was either aware of or who were the best, and I remember looking at Ken Brummel-Smith receiving his thank you for his year as president of the American Geriatric Society. I was aware of him from his earlier work in

California, and he was based in Portland, Oregon, about as far away from Tallahassee as you could get and very different climate. But I pursued him, and fortunately we had some common colleagues and interests and convinced him to come take a look and then come take a second look, and sure enough, we got him. So some of these recruitments, to get really the best and brightest to be part of the school, to create an instant reputation, did take a lot of focus and a lot of energy and a very can-do attitude.

Thomas: Right. I know that one of the major decisions you made related to technology was to teach anatomy using digital media without a cadaver lab. I guess what are the advantages to using that method over the traditional, I guess, hands on cadaver method?

Scherger: Well, the hands on and the appreciation of a real human being are important, and you don't want to lose that ability completely. But on the other hand, a cadaver is all one color, it's old, it's diseased, the anatomy's not clear, it's very confusing; students will do dissections and nothing really is clear. So they'll walk away from that experience confused. By making the visible human technology available and the ability to see it and appreciate it allows for much greater acquisition of knowledge and learning. So what you want to do is you want great knowledge and great learning and growth. At the same time, you don't want to disconnect your students from the reality. But the old cadaver is very much a 20th century medical education kind of right of passage, but not the 21st century model for the best way to teach anatomy. And again, we had the opportunity to do it a 21st century way.

Thomas: If I could shift gears and talk about accreditation – because that, of course, was a major challenge in the early years of the school was to obtain accreditation from the LCME, which it did turn down FSU twice before they were finally accredited in 2002. Could you talk about some of the challenges of accreditation and how you and the faculty and administration met them?

Scherger: Well, it was an enormous challenge, and it was a tremendous team effort, and it went right up to the president of the university. There had not been a new medical school in twenty years, and the requirements of a medical school had been re-written about every five years. And interestingly enough, if you looked at the accreditation requirements at that time, there was nothing about a new school. There was nothing about the realistic development of a new school. All there was was what needed to be in place to be an accredited medical school, which of course was huge in all four years of the curriculum and all the faculty and all the resources. And you were never allowed to even begin recruiting a student until you were fully accredited. So how are you going to do that? I mean, are you going to put in place hundreds of faculty that are going to twiddle their thumbs waiting for students to come along three or four years later? It was unrealistic. The staff at the AAMC was engaged from the beginning before I came with Myra Hurt, and they put together an application that was kind of a trial balloon to see what would happen, because the staff are there to give you guidance and follow the rules, but the actual accrediting committee consists of people all over the country that are really like the board

that makes the decision. So the staff can't always predict what the board's going to do, especially with something completely new. So the kind of trial balloon application that went in before I arrived was just sent right back with the comment, "We approve a school; we don't approve a plan. A plan is not good enough." And so we realized we had a lot of work to do. And we worked very hard to put together the package of the school for the first two years with very good resources in place for years three and four, but we were obviously small because our class size was going to be small and we were still operating out of trailers and borrowed space. I actually thought the second application was really quite good, and the staff at the AAMC felt it was good, and even our site visitors felt it was good. But the actual LCME itself said, "We can't approve a medical school with only one teaching pathologist. What if he dies?" And things like that. So they rejected us, and we appealed and didn't succeed in the appeal. But really, that second process resulted in change, because it was really a high quality application and it was what we had and should have had at the time. It really also allowed the LCME to say, "Look, we need to rethink and have criteria for a new and developing school." And so when we turned it around in about six months, we did add a lot of faculty, we addressed everything they asked us to do, we sailed through the third time. But it was one of the most emotional and professionally taxing and rewarding efforts I'd ever been involved with. And it was a major team effort.

Thomas: I understand that you actually appealed the decision when you found out that the accreditation had not been granted, and also I understand that David Stevens at the AAMC, you know, who is involved in walking the school through accreditation – could you possibly talk about his role as well?

Scherger: Well, David was an optimist, and was probably even misleadingly so to some degree in the early parts. The LCME switches every two years, I believe, between who's in charge – the AAMC or the AMA Council on Medical Education. So actually after the first application was denied, when we went around the second time, things had shifted from David Stevens to the people in Chicago at the AMA. So we had a new group of people to work with. They were very, very helpful, and I think they were always advocates for us . They were concerned about our selling these traditional medical school leaders on the LCME, people from places like Penn and Johns Hopkins, that this Florida State was going to be up to the standard. I think the appeal was a very good exercise, and it was an educational exercise for all of us, but it was very obvious when we got there that their mind was made up before the appeal happened. I mean, they had already made their decision that we weren't ready in their mind and there was nothing we were going to say that was going to change their mind. But I think when we first were denied, they told us it might take nine to eighteen months to be ready again, and we had students already in school. So we had a real problem that the first class might have to be designated a PIMS class, and they were recruited as the first class of the medical school. So this was an enormous crisis. The students were in crisis because they thought they were at Florida State's medical school and they might all have to be shipped to Gainesville and be called PIMS students. That was really disconcerting. But we were able to convince them about six months later while the students were still in their first year that we were able to be accredited, and we

were accredited, and the celebration was enormous and the sense of relief on the part of that first group of thirty students was just tremendous.

Thomas: Sure. It seems that part of the problem was not that you didn't have all the resources that you needed, but that the school was very innovative, particularly in its educational model and the way — like one of the things it did was move the clinical experience for students to earlier in the undergraduate career, you know, undergrad medical career, that is, and also that you set up a clinical learning center to help students develop interviewing skills and diagnostic skills. How did those innovative — how did those types of innovation affect accreditation, and do you think they hindered it?

Scherger: Well, you may get a different answer from different people, but I don't think they hindered it at all. As a matter of fact, I think they helped it. We were doing things that other medical schools wished they could do, but change is difficult. We were also doing things that the AAMC and the AMA Council on Medical Education thought were good ideas. The clinical learning center was actually something that has been growing around the country for a couple decades. Ours was just bigger and better than everybody's else's because we had the space and it was new. Our curriculum was not controversial; it was innovative but it was also consistent with what the leaders in medical education thought ought to be done. I actually think that our innovative curriculum and the talent of people like David Steele, who had a great national reputation, actually helped us. It was purely a size and resource issue. I mean, they were not going to recruit – I don't know how many it was now – maybe eighteen or twenty-some full time faculty – they said you can't have a medical school with eighteen full time faculty; you got to have seventy-seven full time faculty or something like that. I mean, it was purely a numbers - resources issue, but I don't think the mission worthy innovation of the medical school was a hindrance. Our focus on information technology was an asset, so actually I think that we ultimately succeeded in part because of our innovation and leadership.

Thomas: And I realize that I think our time is almost up that you'd said you could devote, but what I wanted to I guess close out with was the ways that FSU is innovative and trying to lead 21st century medical education and yet there is so much in its mission and values that harkens back to some of the reform programs and ideas of the 1960s and early '70s, and I was just wondering if you could talk about, you know, some of the historical influences and you know, what you see as the most important influences from the past.

Scherger: Sure. Well, the idea of community-based medical schools has its roots in the '60s and '70s. You have to remember that in 1960, there were 75 medical schools and by 1980 there were 125 medical schools. So there were 50 new medical schools started in that 20-year period. About half or more of those medical schools were started with state universities public funds and use of existing hospitals rather than private academic health centers. And Michigan State and Northeast Ohio and many places grew out of that heritage. And so we were able to build off that with the new tools and methods of the 21st century information technology and the ability to

kind of rethink community medicine and public health with better information technology. So Florida State is the first community based medical school in that tradition of the information age, and I think that would be a defining characteristic. We have our roots in that community based medical school, service oriented concepts, but the first one of the information age, which creates all kinds of opportunities and identity that way.

Thomas: Thank you so much for your time, Dr. Scherger.

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