Interviewee: **Watson, Robert, M.D.**
Interviewer: **Karen Thomas**
Date of interview: **November 29, 2006**
Category: **FSU College of Medicine**
Status: **Open**
Tape location: **Box #53**

Thomas: Dr. Watson, can you start by telling me about how you came to the University of Florida College of Medicine and your early career as a medical educator?

Watson: It was for purely practical reasons. My parents moved to St. Petersburg from Nashville when I was in high school, and after I finished high school and worked for a while, decided I wanted to go to medical school. I looked to see where the medical school was in Florida and found out it was in a place called Gainesville at a place called the University of Florida. So I came to the University of Florida. Ended up doing well in college and then having an opportunity to go to one of several medical schools. And an interesting twist of fate, my wife worked for the chairman of the Department of Surgery as his secretary. I interviewed at Duke, and Duke offered me a half scholarship-half no-interest loan. So I came home and told Carolyn I was going to Duke. And so she told her boss, Dr. Woodward, that she would be leaving her job late that summer because we were moving to Durham. And I wrote the University of Florida and said, "I appreciate being accepted but I must decline; I'm going to Duke." Two weeks later I got an Avalon scholarship to the University of Florida – a full tuition scholarship. So we thought about it. I liked it here, she liked her job, we could live cheaply. It was during those days where you didn't want to have any debt. So I decided to stay. And when I was a fourth-year student, Dr. Woodward was at a meeting in California and he called Carolyn and said, "My daughter Suzanne's college says I have not paid her tuition. Would you please go to my desk, get my checkbook, and find the check stub – I know I did." And she's flipping through the check stubs and sees "Avalon scholarship," which means, as I always say (and this is never actually been officially done anywhere), she's the only secretary to ever get a full scholarship to medical school. Because Dr. Woodward didn't care whether I stayed or not, but he paid my tuition all the way through medical school without us ever knowing – and he didn't know until the day he died that we knew – so that he could keep his secretary for four years [chuckles]. So that's how I ended up in the University of Florida College of Medicine.

I wanted to be a neurosurgeon, so I went off to Alabama, and halfway through my internship I realized that neurosurgery didn't quite fit my set of talents, decided I wanted to do neurology, and came back. And then I remained on the faculty after finishing my residency. I was doing my residency, I think — I always loved teaching, and I think one of the most thrilling things that ever happened to me was during my residency when the graduating class gave me the Hugh Hill Award. That was an award to the resident who the graduating class thought was the best teacher. And that was the first teaching award I'd ever received and it was actually a big award; it's still a big award around here. So it was positive feedback for doing something I actually loved doing. And I noticed during residency — I just taught everybody – I taught PA

students, I taught nursing students, I taught medical students; I just enjoyed teaching. So I stayed on the faculty and after a while I decided I wanted a Porsche. (So see, I make all these practical decisions [chuckling]). And so I went out to Pensacola; went into practice, bought a Porsche. But once again, I missed teaching so much that I said, "I like teaching more than I like this Porsche." So I came back, sold the Porsche, and I've been here ever since.

Then as a faculty member, I was really fortunate because I won the Hippocratic Award, which is the most prestigious award a faculty member can receive from the graduating class. And that was more positive reinforcement. But I always wanted to be a teacher-clinician. I did a lot of research in behavioral neurology because I thought that was fun and interesting. And had the great pleasure of working with Kenny Heilman, who's the world's best known behavioral neurologist and who happens to be right here. And so it was all fun.

But then when Allen Neims became the dean in 1989, sort of out of the blue he asked me — he was restructuring the dean's office, a completely different organizational structure where he created three senior associate dean positions, one for clinical, one for research, one for education. And he asked me if I would be the one for education. Since I had steadfastly refused to ever consider being a department chairman, at first I kind of laughed it off. But then I thought, "What could be better for someone interested in teaching than to have a broader oversight of the teaching programs?" And so in 1990, I became senior associate dean for educational affairs.

Thomas: What was your first contact with or knowledge of the Program in Medical Sciences at FSU?

Watson: My first contact and knowledge was actually as a faculty member serving on at least two committees that interfaced with PIMS. One was the curriculum committee, because accreditation requires that you have a single curriculum committee that oversees the education of all students, including those at what are called "geographically separated campuses." So we couldn't actually make a decision that would affect just our first year class because we had to consider the curriculum at PIMS and their first year class. Then in the academic status committee where we deal with students who have some academic difficulty – and of course some of the students from PIMS would come up before that committee just like students who started in Gainesville. And that's how I first actually knew anything about the PIMS program.

Then I ended up learning more about it because in an early accreditation, I believe the one in 1992, there was concern raised about the facilities and a couple other things at Florida State for the PIMS program. When anything even indirectly threatens your accreditation, it always gets your attention. So I put together a committee and we went over and met with the PIMS people at great length, actually; we had a wonderful retreat. The provost at the time was Bob Glidden, who was a wonderful person and absolutely committed to doing whatever it took to upgrade the PIMS facilities. And of course, Myra Hurt. Ocie Harris was on the committee, and he is now the dean for the medical school at FSU. And so we set forth some things that needed to be done, and Bob Glidden made sure they were all done. New building, new resources, and ways to try and improve the applicant pool. As you know, historically the applicant pool has varied. PIMS came into existence on the coattails of a perceived physician

shortage. And then after it came into existence, there no longer seemed to be a physician shortage. And once that sort of gets out there, the applicant pool tends to drop off.

Thomas: Someone mentioned a GMENAC Report?

Watson: Yes, there was one that factored in. Kids are real smart, and they look and they see what's hot and what's not. So if MBA is hot, but there may not be a lot of job opportunities in medicine, they think, "Do I want to do four years of medical school, three to seven years of residency — I don't think so." So the applicant pool dropped off. And the matriculants at Florida State, in general, were just not as strong. And so we had that issue to deal with. But it was all dealt with very effectively, very collegially. The thing that also made it lucky for me (and of course, if you haven't spoken with him you definitely should) is that when I got into the dean's office, having never been in a dean's office or having been a department chair — I had enough sense to call Dr. Emanuel Suter. And Dr. Emanuel Suter, who was our second dean, actually came from his home in Alexandria, Virginia, DC, to Gainesville.

Thomas: And you called him in?

Watson: I called and said, "Manny, I need your help." He spent seven years with me. He lived in the Lakeshore Apartments. His wife stayed at home in DC and Manny stayed here and helped mentor me. Manny was the dean responsible for the creation of the PIMS. So it was kind of great to have Manny there to give me the early, early history of PIMS. And as Manny said — the federal government said we needed more medical students and provided capitation funds, and at that point in time was when our educational facilities were expanded here in Gainesville under Manny's direction. And then the PIMS program was started in 1971 at FSU. And Manny was the person who was responsible. There were all the usual justifications about primary care and rural physicians and all this stuff —

Thomas: Minority recruitment.

Watson: It's the same smart kids that, no matter what they say coming in the door, they're going to decide what they want to do [laughs]. It's the same market out there. And Manny told me, he says, "Oh, look, when you get right down to it, it was a much better strategy for us to prevent FSU from getting their own medical school." He said — you won't read that anywhere, but it was perfectly clear to everybody, and he said, "I think it was perfectly clear to Florida State that that was also a wise way to go, and somewhere down the road that might lead to a better time to create a medical school." Of course, it took thirty years, but nevertheless. You should call Manny; he's an absolutely wonderful guy and he can give you some early insight, I'm sure.

And so we had Manny on the committee when we went over and met with everyone. We together created a great plan and then implemented the plan. I have thought from the time that I really got heavily involved with Myra Hurt, Bob Glidden, and got to know the PIMS students, that it was the best inter-university program the state of Florida's ever seen, and probably ever

will see again. It was a really great partnership. And the students who, when they transferred here — of course, some of them were UF undergrads to begin with, but a lot of them were not. And it was fascinating because they were — they easily assimilated into the class, and yet they were proud of their identity as a group. They remained close as a group of PIMS students from beginning to end, and yet they became wonderful members of the College of Medicine, whichever class they happened to be in. And so it was — they added a lot to the class. And in fact, when all the talk started coming about Florida State wanting its own medical school, which was ultimately inevitable and of course only needed the lineup of the right political powers, which happened to be John Thrasher and Jim King – that it would happen. And the truth is – and I've reflected a lot on it – I think the main reason I didn't personally want to see it happen was that it would be the end of a great partnership. Once the FSU College of Medicine came into existence, we did everything we could to help them. I was involved in helping them get their accreditation, for example. My view was very straight forward: our job as educators is to produce the best possible physicians we can regardless of where we have the opportunity to do so. It makes no difference if they're in Gainesville, Tallahassee, or anywhere else. So if Florida State needs our help – and I told this to all my associate deans, "If they call, you do it; very straight forward; no ifs, ands, or buts. Whether it was our counselor or a database person or curriculum – it didn't matter. If anybody from FSU calls, you help them." And we did, and we were glad to do it.

Thomas: When you say PIMS students added a lot to the class at UF, can you go into more detail?

Watson: I can go into detail, and I don't want to sound the least bit critical, but we did have one of these situations where on average the incoming numbers for students in Gainesville was better. In fact, a percentage of the class at PIMS were people who didn't get admitted here; they got admitted there, including one of the sons of my long-standing chairman of Neurology, Mel Greer. I told Dr. Greer that "they'll give him a fine first year education, he'll graduate from the University of Florida College of Medicine." So he came here, and now he's in a prestigious academic position at Harvard. So there you go, there you go.

But in general, if you looked at board scores – which we had to do for accreditation purposes – they force you to look at comparators because the LCME always said, "You must have an equivalent education" – not equal, but equivalent – and the students from PIMS just didn't do as well. Now my view has always been – and I know it's not universal – but my view has always been that the art of medicine is more important than the science. My view has always been that when you focus too much on the numbers, you may well miss some of the very best physicians. There's a difference between making grades and being compassionate. Doesn't mean you can't make good grades and be compassionate, but if I had to choose between somebody who was going to make all A's and somebody whose patients loved them, there is no question which of those I would choose. I didn't want very much focus on these comparators, and I noticed that a lot of the PIMS students came in without arrogance and I think they came in, for whatever reasons, knowing that perhaps they had to struggle a little more. And they were, by and large, wonderful people. They made very good students and went on to, interestingly

enough – and we have the database – they did not come out in much higher percentages in primary care or rural practice or greater numbers of minorities. We looked at over the whole history of PIMS. I know that for media purposes a slightly different story was told when FSU was trying to develop a new school, but since we have the only alumni database, we knew. And we tracked it to the beginning of PIMS. It turns out the percentage going into primary care was 32% Gainesville, 34% who started at PIMS. So was it a significant difference? And the fact of the matter is —

Thomas: That's percentages of those who went —

Watson: Went into primary care. But the most important thing, that always seemed to get lost in the discussion was that we need great neurologists; we need the Michael Okun's (who started at PIMS). We need excellent surgeons; we need a lot of good doctors in all specialties. Let's not be critical if somebody down the line chooses to become a surgeon instead of a family physician. Face reality. These things are in many ways driven by factors that become obvious as you get near graduation. You've got big debt and all those kinds of things.

Thomas: It's interesting to me, though, that the political justification, if you go all the way back to the number of medical schools starting back during and after World War II forward to the FSU College of Medicine recently – there's always the rhetoric about redistributing the physicians, getting more primary care, more into rural areas —

Watson: It sells to politicians.

Thomas: Okay. But you do not believe that PIMS actually accomplished that in any greater numbers than UF already was?

Watson: It's not a belief, it's a fact. We have the data; we have the only alumni database from anyone who ever graduated from the University of Florida College of Medicine, which means for thirty years that included the students who started at PIMS. But it's just so logical and obvious. If you look at family medicine programs in the last few years, do you know what percent of their residency positions is filled with US graduates? 25%. It's nothing unique to PIMS or the University of Florida. It is a nationwide phenomena. So those same very bright college students who influence whether the applicant pool was big or small because they were looking out into the future of years in debt and job market and all that kind of thing, now that they've gone through something infinitely more difficult – medical school is not easy. And the average debt from a public medical school now is $120,000 – the average – from a public medical school. And you've got three to seven years of residency where, if you put it on an hourly wage, you're going to be making about $7 an hour. Just common sense would tell you —. It would be wonderful to think that there are deeply and truly altruistic people who are married to altruistic spouses who say, "Well, somehow or other we'll pay off this $120,000, even though you're going to be a family physician not making very much money. Or, I could become a general surgeon or an ophthalmologist or whatever and we'll be able to take care of the debt

and we can have our children and we can do all the things we've dreamed of doing." And so it's not — people sometimes put it as good-bad or the school didn't do enough. Face it – it's just common sense. And the interesting thing is those wanting new medical schools still do that. FIU took a little different tact in that they want to start an Hispanic medical school. They're going at the multi-cultural side of things, and of course, they have the Hispanic caucus in the legislature. I've just gotten used to it; it doesn't affect me; it doesn't influence me; it no longer surprises me. It's just a fact of life. And all the goals are good. It turns out that if there was some way — and I've given all kinds of ways that I believe it could be done – to increase the number of primary care physicians, because it is getting worse, I would do it. Medicine is becoming increasingly sub-specialized, incredibly sub-specialized. If there were a way to have under-represented minorities, if there were a way to have more physicians practicing in rural areas without good access instead of having three more ophthamologists in Miami Beach, there's no one that believes in that more than I believe in it. Those are critical issues to the healthcare system. It's horrible; it's a tragedy. But we have to face the reality. While we say — and this is just a classic one. (I probably shouldn't say this) – but at the same time the legislature will fund another school to supposedly put out primary care doctors to practice in rural Florida, minorities who also will be geriatricians, which was what FSU proposed, the legislature continues to raise tuition. The legislature does not put a single program in to offset debt. They haven't funded the public health initiative for years at the state legislature. Even if they had a student who could go out and do something in county public health units to pay off school debt and practice primary care, there's no state program to support her or him. Do you know how much the tuition is — I'm sure it's the same at FSU, but the tuition at the University of Florida for an out-of-state medical student is right now? Guess.

Thomas: $30,000 a year?

Watson: $50,000. $50,000. Now that's tuition and fees. That's not room and board, or books; that's tuition. It's not reasonable. So at the same time that they want more primary care, more unrepresented minorities, they don't put up on the other side of the equation. And they seem to have this belief that all physicians are going to become wealthy. But they need to look at what a primary care physician makes and they need to look at the amount of debt they have and realize that it is just simply no longer true. Just think of this, too – another one of my great fears – that the profession of medicine is becoming increasingly elitist, so there's little to do with under-represented minorities specifically; there's a lot to do with socio-economic class. Because if you're from a middle class family, not to mention lower class, and you do a little work and you say, "God, you're going to have to pay how much tuition and you're going to end up with how much debt?" And there's just no way. The parents are going to say, "You need to go get yourself a job." And so that's exactly what we're seeing, and it's frightening. So we're seeing, in my view, an increasingly elitist group of students in terms of socio-economic class, and we have set up systems, both political and healthcare, that absolutely discourages people from being primary care physicians, from practicing in inner cities or rural areas. You couldn't design anything to be more discouraging, which is tragic. So it says nothing about the percent of primary care physicians who came out of PIMS compared to Gainesville; has nothing to with it.

You can compare the numbers anywhere in the country; they're all going to be the same. As a matter of fact, when you go to AAMC (Association of American Medical Colleges) meetings, it's just one of these things people laugh about. "Oh, yeah, gonna produce more primary care physicians. Right! So are we." It's a tragedy.

Thomas: Well, I want to shift gears a little bit to talk about curriculum reform, which you've been very involved in at University of Florida. And can you talk about what were some of the things that the administration at both UF and FSU hoped to accomplish through PIMS, and were there things that PIMS could do that it was more difficult to do at University of Florida because it was a bigger, more established entity.

Watson: I think maybe some intangible things – like I think that there were benefits to being in a first year with thirty classmates instead of eighty-five. I think you get to know each other better, I think you probably have better contact with faculty. I think – and this is educationally debatable, so you will find people that will come down very solidly on either end of this argument – my personal view is that you're better off having fewer teachers who can maintain the consistent theme throughout a course. So you have two people teaching your biochemistry course, two faculty, and they've got their style and their broad organizational structure. They get to know the students, students get to know them. The other argument is, what you want is a bevy of people at the cutting edge of their specific area of expertise in the field of biochemistry. So you don't want just two faculty, you want thirty faculty. If you're learning about lipid metabolism, you want somebody teaching the students who's on the cutting edge of lipid metabolism research. Well, since I actually think the former is better, I liked the PIMS approach. But not everyone would agree. It just turns out I like that approach.

The other thing that PIMS did which we could have done here, that we learned – I learned it – was they ended up doing more clinically-oriented things during the first year. So they had their preceptor program where students actually were able to go out and spend some time (I think every week) with a practicing physician. We could have done it here but they were already doing it, and we learned that from PIMS. But other than that – because when it looked like the PIMS might not make it – when things were looking bad before the retreat and all – we had already looked at what we had to do to accommodate thirty more students in the first year. You always have to have contingency plans, so we had already looked, and we could have done it just fine. I preferred that we did not have to go that way, which is why I convened the retreat. I wanted to keep PIMS alive, and that's the way it ended up working. But having to go through that process made me sort of objectively look with interest at the question you asked. We could have done it here. A little difference in style, but as I said, a lot of those things are intangible, and different opinions on them anyway. I wanted – I presented – and I still keep this because I thought it was one of my better ideas, and that was to really make the PIMS a primary care track at the medical school, an innovative curriculum where they actually would go into primary care clerkships after their first year of medical school. And it would just sort of keep them focused in on primary care, almost prevent them from seeing bright lights-big city kind of — [chuckles]. But it never made it; it just never made it. I remember Larry Rooks, now the Director of AHEC, who thought it was a really wonderful idea. I remember we talked about it all the way back from

Tallahassee one day. But it just – like a lot of ideas, just hard. Sometimes when you try to be a little too innovative, it's much more difficult; it's sort of better to have an evolution than a revolution, it seems.

Thomas: So the main innovations in the curriculum were earlier clinical experience —

Watson: Yes.

Thomas: There was — very early on in the '70s the pharmacology course had been moved around from the first to the second year — I guess, were there any other reforms that you either tried or succeeded in?

Watson: No. And that one was one of those things that I alluded to earlier, about making curricular decisions here that will influence what goes on, what would go on at PIMS. And the whole pharmacology thing was because we had a continuum with a fourth-year pharmacology course elective – well, actually it was a fourth-year requirement. And that all changed; we went back to having an earlier pharmacology, but that meant that PIMS had to develop an earlier pharmacology. It worked out but it was not a great and brilliant curricular move. But I do think that the smaller class size – I believe that that influenced Florida State's College of Medicine's decision to have the community groups, to try and maintain that smaller class size atmosphere, which is a critical thing to do as the class size gets larger. I wish we had never gotten above 100 here, because it goes from critical mass to critical morass or something.

Now the AHEC is real interesting because what actually made our end of first semester preceptorship possible was the AHEC. We couldn't have done it without AHEC. And the reason that's such a fascinating story is that Ocie Harris was here for like thirty years on our faculty. Ocie and I – Ocie used to be the head of the Curriculum Committee and he was head of the Admissions Committee – worked together for years and years and years. Wonderful person. So we were going to a Southern Group for Educational Affairs meeting, and this was 1990 or '91, and we decided to visit the North Carolina AHEC, because Gene Mayer was the head of their AHEC. It was clearly by far the best AHEC program in the country. Ocie set up various meetings with people in the North Carolina AHEC, and we took a couple days and visited three or four of their sites. And we decided, "Boy, we need an AHEC." And I came back home and I told the dean, Allen Neims, "We need to put in a grant to have an AHEC." And I said, "The person who should head it is Ocie Harris. He's perfect." Allen agreed and told us, "Write the grant, and Ocie should be the director of AHEC." And then Allen got a little feedback from two or three faculty who will remain nameless that,"Ocie Harris just doesn't have the administrative skills to do that." So the way I tend to solve such problems is I said to Allen Neims, "Let's all meet in your office around a table and we'll discuss this issue." And he called them in and I ran through the reasons why Ocie Harris was perfect. And they never opened their mouths. They were fine to go behind the scenes, but around the table, not a word. Ocie wrote the grant. He not only got the grant and started the North Florida AHEC, but he became known as "Mr. AHEC" in the state of Florida. As other regions started, they came to Ocie Harris. He was brilliant. He was perfect, just like I knew he would be perfect. Well, because he was so perfect,

when Florida State started their medical school, guess who they asked to build their community programs? The most logical guy in the whole state – Ocie Harris. He knew everybody out in these communities. And as it turns out, when the founding dean at FSU got relieved, guess who became the dean? Ocie Harris. So I kid Ocie; I say, "Ocie, you became dean because of that trip we made to North Carolina." And the truth of the matter is it's true. It's true. When you look back at the long and winding road, you can say, "That's how it all started."

Thomas: About when was that trip and when did the North Florida AHEC get started?

Watson: I think the trip was early, like 1991. I think we got back and I believe it got started in '92. It was very early. And of course, Ocie can tell you precisely since he wrote the grant and got it done. I went to one of his original, early – one of his early sort of organizational meetings here with a lot of community doctors. He said, "I guess your first question is, 'what the heck's an AHEC?'" He was just perfect, he was just good ol' Ocie Harris. And it worked out. And of course once we had the AHEC, then we could do a preceptorship where every student at the end of their first semester of medical school could go spend time with a primary care physician, preferably in a rural community. And we did that. And it's been phenomenally successful.

And as you might imagine, we've also looked at whether that early experience had any significant impact later on the percent of the class who chose primary care. And now what do you think your answer will be, now that you're so well educated on all these factors?

Thomas: No.

Watson: No. A lot of them came back and we did all these surveys. And of course, immediately after doing it, they loved it, "this is wonderful," "this has opened my eyes," "my family physician or my rural pediatrician was just wonderful, just wonderful." But then that's the end of the first semester, the first term of medical school. By the time they're ready to decide on a career, it's long since faded. But that's how we started the AHEC.

Thomas: It is 10:30; do you need to cut this off?

Watson: No, it's fine; keep on.

Thomas: I'm reading from the abstract for your article, "Rediscovering the Medical School," which appeared in *Academic Medicine* in 2003, and one of the suggestions that you make is that medical schools need to link education to the provision of health care to the under-insured. And that certainly sounds like it's in keeping with some of these goals that we've been talking about that are very difficult to achieve. Would you care to talk more about that? And was PIMS at all involved in that?

Watson: Here was the specific proposal I actually had in mind and which I couldn't put in any detail in that article. But my idea was that the state, which provides Medicaid money

through a state-federal match, that what the state should do is look at a medical school and say, "We are forming with this medical school a Medicaid-based contract. That contract will be X-millions of dollars. In return, the medical school will be responsible for providing care to all Medicaid and uninsured patients within a defined geographical region." In my laid-out view of this, it would solve many, many things. One is it would help me achieve what I call a cadre of teaching faculty. So remember when I said I like the idea of a couple of teachers teaching biochemistry rather than having a bevy of cutting edge researchers teaching little bits and pieces? I think you need to have dedicated teachers. I don't think you can be a dilettante teacher. You can do it okay, but real great teachers do a lot of teaching. And so I would take my cadre of teaching faculty – clinical teaching faculty – they would then be responsible for providing the care to that population of Medicaid, uninsured, and under-insured patients. And it would be among that population of patients that the teaching of medical students would occur.

Thomas: Usually the patients at teaching hospitals have been indigent patients, so this is —

Watson: Right. So what it does, though, there's a lot of practical outcomes. Because at a medical school like this, 6% of our budget comes from the state – 6[%]; not 60[%] – 6[%]. And about 60% comes from patient care revenue. Which means there's a driving force to generate patient care revenue. Well, if you can separate the money provided to a state-federal matching program to try and help care for the under-insured from the money-making part of things, then the physicians over there who are driving to generate RVUs (Relative Value Units - equals income) will have the ability to go ahead and do that. Whereas the clinician teachers now have their population of patients. They have a revenue stream to care for those patients, and they have a mission: teach. Care for the patients and teach. We just separate these things. And you avoid all the discussions about how many Medicaid patients will we take in the clinic, how many uninsured can we possibly see. And if you don't think those conversations go on — they go on, because if they didn't go on, you'd go belly up. It's just a fact of life. So the students win, the patients definitely win. People always say, "Oh, it sets up a second-class system." Good God! If they don't think we have a second-class system now, they aren't looking! We've got 46 million, I think it just went from 43 to 46 million uninsured. We've got people who – they end up in the emergency room and they end up in the ICUs where a little preventive care would have saved thousands, tens of thousands of dollars on a single patient. It makes — we don't have a health care system – it makes no —

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Watson: — sense. So this idea, which I actually went over and presented to a top aide of Governor Bush's who actually loved the idea. And I believe that Governor Bush's Medicaid HMO plan came out of that meeting, even though it never got to the medical school level. But the pilots they're now doing (which happens to include our campus in Jacksonville), I actually believe arose in part from that conversation. That's what I meant in that article about linking education to caring for the under-served. You link it directly and it has all kinds of practical, positive benefits. And I honestly saw very few downsides. Now there would be some tricky things, like you'd have to have a separate clinic. But that's great, because that unplugs all kinds

of people coming in the emergency room. That unplugs the clinic so that they can take as many paying patients as they want in their clinics. You have to have contracts with the hospitals, so if somebody gets admitted, there's no question they get admitted; they get cared for just like anybody else. So there are all these little logistical practical things. But in fact, the whole idea of mission-based anything is just aligning money with mission. Stop all the hypocrisy. It doesn't go on just in the legislature; it goes on in this country's medical schools; it goes on all the time, this hypocrisy of "oh, we're a safety net" or "we need more primary care physicians. Oh, the way we're going to accomplish that is charging them a gadzillion dollars in tuition and not helping with any debt forgiveness. The way we're going to take care of the underserved is to limit the number that can be seen in the clinic and not provide preventive care." It's just complete hypocrisy. And so to me what you do is you step back and look at your missions. You have a mission to take care of patients. You have a mission to educate. You have a mission to do research. And then you try to align funds, people and research to accomplish the missions. It's not a very complicated concept, but somehow or other it seems to be lost in loosely coupled systems like we are, and people have their turf and whatever to protect. Did I make that clear? That was awful rambling from that one little quote out of that —

Thomas: I think I understand what —

Watson: That's from where that idea came. By the way, that article, at least in the founding of Florida State's medical school — you can tell a lot of similarities in what they have done. Ocie told me it sounded as if I was writing about FSU. I don't know what FSU is going to do in the future. It always worries me when they're building research buildings and all that stuff. But there are a lot of things in that article that were done in the founding of Florida State's medical school. A lot. Which was intentional on their part.

Thomas: And you know, and the people that did found the FSU College of Medicine have said that it in turn owes a lot to PIMS. One thing I did want to ask about was when you talk about medical centers have placed increasing emphasis on research, and "clinical business" is the term you use and less on the mission of teaching, less on medical education. Do you think that PIMS helped University of Florida keep a closer focus on teaching —

Watson: No.

Thomas: — during that period? No.

Watson: But I think that Ocie and the founders of PIMS recognized that as a nationwide problem and worked hard to at least in the outset not allow it to happen. Because they took their lines, their FTEs, and hired people to teach. They didn't hire people to do research; they didn't hire people to do generate lots of RVUs. They hired them to teach, and that was their job. Now there's a little funny downside to that, and that is that since we tracked faculty effort better than anybody in the country, because we've been doing it for so long – it's virtually impossible to be 100% teacher in a medical school. It's just virtually impossible. Biochemistry lasts one term.

Even if you give all the lectures, and you gave twenty hours of preparation for every hour of lecture, it wouldn't come out to 1,920 hours a year. It just wouldn't come out. So that becomes a little bit of a problem, which has led to another one of my ideas — well, I think it was in that paper, and that is what you need is health science center educators. You need someone who can teach biochemistry to medical students and teach the biochemistry course to nursing students and teach the biochemistry to PA students. Just shift the level of complexity of their teaching. Then you could generate a 1.0 FTE, but other than that it's hard to do.

Thomas: At FSU they were using basic science department members to teach first year medical students. And there is some challenges with that. And someone I spoke to talked about how medical schools have evolved their own separate medical school departments to teach medical students and there's less and less interaction with the basic sciences. Like there's biology over here and biomedical biology over here, and they don't —

Watson: It was always problematic with PIMS. The truth of the matter here is the colleges on campus, mostly in the College of Liberal Arts and Sciences, had absolutely no interaction whatsoever with College of Medicine faculty or teaching. So even though there's a biochemistry division on campus, they don't teach any biochemistry at the medical school. Even though there's a world-class, an enormous microbiology part of IFAS (Institute for Food and Agricultural Sciences), they don't teach in the Department of Microbiology in the medical school. It is just as separate as you can possibly be. Whereas at PIMS, since they didn't have a medical school, they had to use the faculty who were available. The PIMS students over the years – and we would survey them all the time – one of their greatest complaints was lack of clinical relevance. They had the preceptor experience, but in the classroom they did not perceive that they were learning the basic sciences within a clinical context. Now the truth of the matter is that what made that more possible here is — well, there were two things – three things. One was our basic scientists were in the College of Medicine, not a College of Arts and Sciences. That meant that they could interact with the clinical faculty. It might be on research project; it might be in the faculty dining room, but they interacted with them. And the other thing that was good or made it possible was that you're all one big faculty. So if anatomy wanted clinical relevance, they could ask an orthopedic surgeon or a gynecologist to come and help in anatomy. I still give lectures in neuroscience, and they're very clinically – "this is why neuro-anatomy is important for you to learn" kind of things. Makes a big difference. I think to the students it may seem more important than it actually is, but a lot of it is perception. And there was no question that the number one complaint, if you will, that we heard over and over from the PIMS students was no clinical relevance. I think one of the reasons that they enjoyed getting here was there was a lot of clinical relevance. Now what they didn't recognize at the time was they would come to courses that lent themselves much more naturally to clinical relevance, like pathology [laughs].

Thomas: Different part of the curriculum.

Watson: It's a different part of the curriculum, exactly. But nevertheless, I do think it was

more difficult to depend on, fundamentally, faculty from Arts and Sciences to try and teach. It turns out they had some great teachers, like Ouimet met who teaches neuro-anatomy, neuroscience over there — Ouimet who, I think, a year or two ago, won one of these FSU-wide teaching awards – Charles Ouimet. This was always an interesting little aspect to me: while FSU would try to promote the number of primary care people that they produced, embarrassingly enough to us, an enormously higher percentage of students who started at PIMS ultimately did neurology than students who started here. As a matter of fact, there was a string of about four years where every single year our chief resident was a PIMS student [laughs]. It was ridiculous. Annie Rottman, Michael Okun, it just went on and on. And I would ask them, and they would say, "Oh, it was Dr. Ouimet. Dr. Ouimet, he was so fantastic. He was just a pure teacher over there who taught them neuroscience, inspired them to become neurologists. Now if I were at FSU, I would be bragging about that to the top of the mountains, right? We have this big giant neuroscience course taught by fifty faculty and residents and neurosurgeons, psychiatrists and neurologists. Few students chose to go into neurology [laughs]. So there you go. It was all Charles Ouimet; it was one teacher, one teacher. And they held him in absolute reverence.

Thomas: I think the last question I'd like ask to kind of wrap up the interview is would you like to talk about how PIMS changed over time from the time that you came in? You talked about that retreat; that was obviously a pivotal moment. What was PIMS like when you found it and what was PIMS like when it ended in 2000?

Watson: I think like all things it probably depended in a large measure on the leadership here and the leadership at FSU and the amount of interest. So in the beginning it was so natural because Manny Suter initiated it and Paul Elliott went from the University of Florida to Florida State to be the director. So what more natural link could there be? A lot of enthusiasm at the beginning, like always. And then as time went on, I think that the deans here may have had more or less interest in the program. They had their own fish to fry over here, and sometimes they could be – I'm imagining something that was not high on their radar screen. And the only way it would get on the radar screen is if the LCME, the accrediting body, came in and sort of gonged you for your program – and it was <u>our</u> program over in Tallahassee. I can remember going through a time when we kind of agonized about PIMS. It was in the '80s – it was before I got in this job. We'd look at those Step One board scores and "Oh, god, what are we going to do, what are we going to do?" A lot of those kind of conversations. I'm not going to take any credit, but I think Myra Hurt made a huge difference, because she was completely committed to the PIMS program. She had almost parental arms around the program, and she seemed to be more of a driving force. Now that didn't mean that sometimes she wanted to drive in a slightly different direction, and it didn't mean that we didn't get into tussles. But that's the nature of life. It's like our urban campus in Jacksonville – love it, but they sometimes want to go a little different direction and you have these fairly frank discussions about what's best for the medical school in general. Those are healthy discussions. Myra was never shy to express her opinion, and I give – at least during my time – a large amount of the credit to the improvement in PIMS to Myra. Now Myra in turn, I think, and I don't know her perception about this because we've never talked about it, I think she benefitted greatly from the support of Bob Glidden. Because

Myra probably wasn't aware – Bob Glidden and I were on the phone a lot, not just over there in retreats, but we were on the phone or we were emailing. I always believed that he was completely committed to one: keeping PIMS, and two: making it the best it could be. Something that the University of Florida could be proud of. Now if he had in the back of his brain that he was going to make it the best it could be to some day become its own medical school, that's fine. And then I will say I was completely committed personally to making it the best it could be. I spent an inordinate amount of time. I've got notebooks – they've finally taken them to the archives, but they used to fill one of those shelves – pure PIMS, all PIMS. I went back to the beginning of the history of the place, got the original documents, everything. Read everything. Because it was such a great program. And I actually wanted to see it expand to two years. Two years there, two years here would have been my ultimate best solution, I think. And then have it be a primary care tract; just didn't work out. But I happened at that time work for a dean, Allen Neims, who was just fantastic. Allen was one of these wonderful rabbinical people who if his senior associate dean thought this was important, then it was important. He wouldn't say, "What are you doing wasting your time —" ever. And retreats and money and whatever, he was completely supportive. So once again I think, when you get a supportive dean then you get somebody delegated who is interested in trying to make something better, and then you have people in whatever program who have absolutely the same goals and who happen to be very effective people, the Bob Gliddens of the world. I thought Bob Glidden should have been the president of FSU, but that's a different story. He left; he became president of Ohio or something like that. Do you know?

Thomas: I honestly don't know.

Watson: I think University of Ohio — he was a wonderful guy. And so Myra and Bob Glidden, and then I think, although he wasn't the founding dean, I think Ocie had a lot of knowledge of PIMS and a lot of knowledge of a much more traditional medical school like this one. And he was able to coalesce those things. And I think Florida State College of Medicine was so lucky that way back there in 1990, Ocie and I went to North Carolina, because he to me was the perfect guy to pull it all together. "Easy Ocie." Pull it all together and move the school forward. I still miss the PIMS. I just think that there is something — see, in one of the early questions you asked me about intangibles. I came up with some intangibles idea. The same sort of thing exists in Jacksonville. It's urban. This is Gainesville. Jacksonville is urban. It's got this large University of Florida Health Science Center Jacksonville/Shands with a different kind of patient mix. And I think students — right now what happens is every one of our students spends about 25% of their clinical time in Jacksonville. What I would hope to see down the road is about 25% of our students spend their last two years in Jacksonville. They'll get a different but equivalent education. I think there's maybe a chance to inspire caring for the under-insured. There's something – even though it's hard to put your finger on a lot of specifics – there's nothing wrong with intangibles, there's nothing wrong with feeling like — that there's something nice about diversity, there's something nice about different, not being too lock-step. It makes for the whole to be better than the parts.

Are you going to call Manny?

Thomas: I'll go ahead and cut off —

End

Addenda:

Watson: I think the other thing for which we were very fortunate as it turns out, having Manny Suter during those early years and involved in all the discussions, because Myra Hurt, in fact, everyone, loved Manny Suter. And I think the reason was, Manny was the most remarkable person with whom I've ever worked. He was the school's second dean, but he was completely without ego. I have never met anyone like Manny Suter. Manny Suter wanted to do things to make education better. So having his name attached to it, being in Tallahassee or Gainesville, none of that mattered, none of it mattered. He was just patient, understanding, would encourage people. He spent untold hours working with Larry Rooks, who at that time was chair of our curriculum committee, now head of AHEC. When we would have a curriculum committee retreat, I would turn to Manny. Manny would organize it. Manny just had all these wonderful ideas. So we had all those great experiences, but you would never know he had been our dean. You would never have known he had been the first chair of microbiology. You'd never know that he had been at the Rockefeller. He was just the most humble guy with the most altruistic motives. It was hard not to absorb some of that. If you were around Manny, you wanted to be like Manny. You just couldn't help it. And so I actually think one of the really key things to turning things around was probably Manny's influence. Working behind the scenes and helping plan the retreat and being there. Like I say, nobody could ever question Manny's motives. They may question any of our motives – after all, it is FSU and Florida, those kind of primitive Olympic-level things that don't exist in this arena. But you could never question Manny Suter's motives. He's pure as the driven snow. I love Manny Suter; I just adore him.

Thomas: I did think of one thing — I talked to Paul Elliott and he was involved at the national level with AAMC, and you also have been quite involved with AAMC. Was AAMC very aware of PIMS or what was being done down here? And you'd also mentioned that you had been instrumental in helping get the FSU College of Medicine accredited. Could you talk a little bit about the connection between AAMC and —?

Watson: Well, AAMC, of course, at one level just knew about geographically separated campuses rather than having a specific interest in one or the other. Through the LCME, the accrediting body, there was so little movement towards separate campuses because they shut down the Minnesota-Duluth program. In other words, they didn't want any more of these sort of two and two separate medical school kinds of part programs. I know that when FSU started its drive to have a new medical school, everyone that I knew at the AAMC and the AMA kind of thought it was not a great idea. I think that was for a couple of reasons. One was we were still in the Weiner era of "there's going to be a huge physician surplus." And the other thing was it was so politically driven, which always drives organizations like the AAMC a little crazy. But it was well known that it was politically driven. The fact of the matter is that's the only way it would have happened. Face the facts. And it turns out, guess what? John Thrasher and Jim

King were right. I don't know if they were aware at the time, and probably were not, but the fact of the matter is while everybody else was saying there's going to be a huge surplus, they pushed right in and started a new medical school which forms before a new dawn; there's a huge shortage of physicians. So FSU is the first new medical school in twenty-five years. So the LCME had to go through learning how to accredit a new school since they hadn't accredited a new medical school for twenty-five years. So they kind of developed policies and sharpened their knives on FSU. Now this sort of aberration called the FSU College of Medicine turns out to be the first of a new era. And now lots of new medical schools are opening. UCF, FIU, other states, people are expanding class size like crazy. Well, guess who in the rearview mirror of history is going to be seen as the school that was the first to do that? Florida State. And only people who might read back through history will realize they actually did it right in the middle of everybody saying, "We have a huge doctor surplus! What are you doing?" And so Thrasher and King, whether they realize it or not, were ahead of their time [laughs]. But it's kind of — and all these new schools now have got FSU to thank because they made the LCME figure out how to go about accrediting new medical schools.

Thomas: Why was it so difficult for them to get a new accreditation?

Watson: I think that's easy. I don't think that was just because the LCME was stumbling over what to do. The LCME, I think they need to rethink one policy, and that is a timing issue. Because when they went over there to try and provide provisional accreditation, FSU was still trying to build your buildings [laughs]. It's impossible to have those things in place. I've talked to the new dean at UCF, Debbie German, and the time line for her to get it all together for provisional accreditation is – it's close to being unrealistic. So I think that's why they did have problems. It wasn't a lack of committed resources, it wasn't a lack of having thirty years experience in medical education. I just think it's a time line issue. Give me two years to at least have the buildings built [laughs]. When they went back and were able to see what FSU had in place — and in fact a couple really model things like their faculty development programs — I didn't think there was any question that they'd get accredited. And you know what? I worked to help them, and my part was actually just the first two years that Ocie asked me to help with. I made lots of suggestions and wrote a long report. But I didn't have any doubt — I didn't know how the last two years would fare, but I didn't have any doubt that the first two years would get accredited. I just didn't have any doubt.

Thomas: Thank you very much for your time. Is there anything else you wanted to add?

Watson: No.

End