

Lowell Anderson, D.Sc.
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

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

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

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

Biographical Sketch

Lowell Anderson was born in Hoodspport, Washington. His family moved several times, but he spent most of his early life in East Tennessee. He earned his bachelor's degree in pharmacy from the University of Minnesota in 1962. He was President of Watauga Corp, which operated Falcon Heights Pharmacy and Medical Supply (1966-1996) and Bel-Aire Pharmacy, a community based health center in White Bear Lake, MN (1981-2006). He left private practice in 2006. Throughout his career, he has been highly active in professional organizations and served as president of the American Pharmacists Association, the Minnesota Pharmacists Association, and the Minnesota Board of Pharmacy. He has also served as an industry advisor, on several boards of directors, and on national steering committees. In 1995, he was awarded an honorary doctorate from the Philadelphia College of Pharmacy and Sciences for his local, national, and international efforts. While in private practice, Anderson continued to play an active role in the University of Minnesota's College of Pharmacy. He was named advisor to the dean from 1994 to 1997 and participated in many committees from the 1980s through the 2000s concerning planning, evaluation, and curriculum development. Anderson has served as co-director of the Center for Health Care Change since 2008, an adjunct professor in the College of Pharmacy since 2009, and manager of the UPlan MTM network for the University's employee health plan since 2009.

Interview Abstract

Lowell Anderson begins his interview with a reflection on his early life and education, highlighting his experience earning a bachelor's degree in pharmacy from the University of Minnesota. He describes the profession's receptiveness to female pharmacists, his recollections of the Kefauver Hearings regarding prescription drug pricing in the early 1960s, and the impact of managed care on pharmacy. He goes on to discuss his professional goals; his time at Walgreen's as a pharmacy student; his early career, including time at Northwestern Hospital and the State Department of Administration; and his experience of ownership of pharmacies in Falcon Heights (1966) and White Bear Lake. Within this discussion, he reflects on how relationships between health care professionals and pharmacists change in different venues, the differences between a chain pharmacy and a privately owned pharmacy, building community relationships, generic substitution, the patient package insert, patient expectations regarding drug advice from doctors and pharmacists, the function of Pharmacy Benefit Managers. The conversation then transitions to the Academic Health Center and Mr. Anderson's contributions to the College of Pharmacy. The following topics are discussed: the introduction of clinical pharmacy in the College; relations between basic scientists and professional pharmacists in the College; relations among schools and colleges in the AHC; the potential creation of the Pharmacy Technician Program; the threatened shortage of pharmacists; the creation of the Department of Social and Administrative Pharmacy; the development of pharmaceutical care practice; and the Center for Leading Healthcare Change. He concludes his interview with current policy issues in which pharmacists should adopt a larger role.

Interview with Doctor Lowell J. Anderson

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed in Weaver-Densford Hall on the University of Minnesota Campus

Interviewed on August 1, 2012

Lowell Anderson - LA
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Lowell Anderson. It is August 1, 2012, and we're in Doctor Anderson's office in Weaver-Densford Hall.

Thank you for meeting with me today.

To get us started, can you tell me a little bit about where you were born and raised and your educational background?

LA: I was born on the Olympic Peninsula, Hoodspoint, Washington. My dad [Waldemar Anderson] was with the United States Forestry Service. When I was four years old, we moved to Minnesota, which was my parents' native state. From there, we moved to East Texas where I started grade school. East Texas in 1945 was about eighteenth century in development terms—pretty backward. From there, we moved to Tallahassee, Florida, again in the first grade. Then, in the first grade, also, we moved to East Tennessee where I spent the rest of my primary and secondary school.

East Tennessee was pretty unique. It's very English. A lot of settlers came over when they drove the Crofters out of Scotland. They still have festivals there [in East Tennessee], and you still find Elizabethan songs sung in the hills.

I graduated from high school in Tennessee and started college in the Upper Peninsula of Michigan at Gogebic Junior College [in Ironwood]. I went there for one year and, then, came to the University of Minnesota and entered the pharmacy program and finished in 1962 and stayed here. I've been here ever since. That was my education. I graduated with a bachelor's degree in pharmacy—that was what was offered then—and did not go

back and get a Pharm.D. degree when it became available. I think the reason for that is I was too well launched into my career and didn't really feel that it would provide value at that point. That would have been twenty years in, so I didn't do that. That's my education and childhood.

DT: What led you to pursue a career in pharmacy?

LA: I started out in medicine. I wanted to go into medicine. I think the bottom line probably is I didn't have a passion for medicine. I had childhood friends whose parents were physicians, and I was intrigued with it. My older brother [Bruce R.] went into pharmacy after he got out of the military. So we talked a lot about it. I said, "Yes, that sounds pretty interesting." It certainly brings in medicine, but without the tremendous demands on schedule and education and a whole bunch of other things. It was a good choice.

DT: What was your experience like as a pharmacy student here?

LA: We were at Wulling Hall. Wulling Hall—I came here in 1958—was unairconditioned. The labs were hot. They had a patch of marijuana growing outside the front door, which no one bothered to molest. It was probably the most vibrant patch of marijuana in Minnesota—after all it was nurtured by Ph.Ds.

Someone was doing research on it.

We only had thirty-one in my class at that time, and seven were women, which was a pretty good percentage at that time. I don't think it switched to a majority for another fifteen or twenty years. There were several older students—although, I was not one of them—in the class. It adds a certain amount of reality to a class when you've got that. A few were married, certainly a lesser percent than today.

I think senior faculty consisted probably of fewer than six. It was a very senior faculty. The most junior one was in chemistry, and he'd just come from Wisconsin. Of course, he was shaking up the old faculty, because he had new ideas. All faculty members, at that time, were really involved in the profession. That's changed over time. A number of the faculty members had been officers in the state professional society, attended professional meetings. The dean was the same way, as is with our current dean. We have a huge faculty today, and I think a minority are pharmacists. There's not a similar interest in those professional societies or their professional issues today. The faculty and the students were quite close. Although, there was still respect, they were still called "professor" or "doctor." They would come to fraternity meetings, student parties, and so on. We really got to know them as individuals. In many cases those relationships continued for many years after graduation.

Fifteen, twenty years later when I was president of the state association, one of the most respected faculty members finally told me to call him Frank. It was one of those big events in my life when Doctor DiGangi said, "Call me Frank."

LA: I knew I had arrived then. That was the relationship we had. It was kind of cool. I think it was a good relationship.

We graduated in 1962. The group, as small as it was, and as close we were, we kind of split up. It's our fiftieth class reunion this year, and I've been trying to update our list of contacts. Some of them, I just can't find! They're not licensed. They're not a member of the Alumni Association. They've literally disappeared. They may be dead for all I know. Personally, I keep in reasonably close touch with only one of my classmates. I know where a couple others are and that's it, so we kind of spread out all over. I don't know if that continues today or not. I think it's kind of unusual in professions that you split up that much. But we did. We had some classmates that really accomplished some pretty neat things professionally, both in terms of commerce and education and leadership in the profession. It was a good group.

DT: What were some of the classes that you were taking? What were the most memorable ones?

LA: Probably the most memorable one, again, was Frank DiGangi's class. It was quantitative analysis. It had a basement lab, and it seemed like the labs were in the spring when it was hottest. You'd have to do quantitative assays of the ingredients in urine and eggs and all those things. It stunk. Frank was one of those for whom the answers had to go out to the fourth and fifth decimal place. He taught us that certain things in life were of fourth and fifth decimal place importance, but not all things in life. Those were really good.

Then, we had another professor who taught—professors were characters—history. It's the only thing that I remember he taught; he may have taught something else. He always lectured from three-by-fives. If we particularly felt feisty, we'd go up and shuffle his deck. Then, he was totally lost, and he would adjourn the class. So on a nice day, like today, we'd shuffle his deck.

DT: [laughter]

LA: Then, we had a pharmacognosist—a course that isn't even taught anymore. That's plants, and medicines coming from plants. That's one of the reasons I came to the University, because he had world stature and that was reflected in the standing of college. One of the people in his department would assign us readings in books—I remember a French book—and he said, "There's no English translation. But there will be questions on the test."

LA: We just decided to flunk that part of the test. As a course it was very detailed. In comparison to a lot of the courses that are offered today it was simple. In retrospect life was simpler then.

DT: Do you remember the name of the pharmacognosist?

LA: Doctor [Earl B.] Fischer. He was a character, a British sitcom type character. He had a little fishbowl on his desk. I don't know how many decades ago it had dried up. It was just the sand and some dead weeds. I suppose if you had dug around in it, you would have found the skeleton of a fish. It didn't bother him.

DT: Did you get any teaching about the business of pharmacy?

LA: We had one professor—Dr. Robert Miller who did teach business. He was a consultant for 3M and did a lot of consulting for the industry. He wasn't well respected within the faculty, because one of the things he would say is, "If you can't do, you teach." Then he went one more and said, "If you can't teach, you become a dean." That didn't endear him. He was one that would talk about macro health issues and economic issues. He'd talk about the stock market and how that related to the health industries and so on. He was probably the closest thing we had within the curriculum to a liberal education, because he had such wide interests and experiences. Other than that, we had to take econ courses outside of the school and so on, but nothing specifically business.

DT: Were you taking any liberal education classes also or was it all...?

LA: We had the option there to take electives and so on. I remember one of the times I wanted to take anatomy, and my faculty advisor said, "I see no reason why a pharmacist would need that." He wouldn't let me take the course. Instead, I took Latin and Greek medical terminology, which turned out to be one of the best courses I took that had utility forever. I liked words anyway, so this helped.

What was interesting within the curriculum at that time—we talk about this occasionally—is that none of us can ever remember hearing the word patient in four years of school. It was just not the focus of the program. It was drug focused, period. The chemistry and activity of the drug but not in relationship to a person—a patient. Of course, that's totally reversed now. The person or patient is appropriately the focus of everything in today's curriculum. That is a big change. I don't know when that occurred. I'm not even sure anyone could really tell...possibly, under the aegis of Larry Weaver, when he was dean. He was a big proponent of growing the clinical components of the curriculum. So I suspect that he may have put that into the working vocabulary of the faculty.

DT: When you were a student, did you have any interactions with the medical students or any discussion about how as a pharmacist you would interact with physicians?

LA: No. The closest we got was we took a pharmacology course with the dentists. They sat on one side; we sat on the other. We did better than they did. The only discussion back and forth was asking for help on their side. I didn't see that carry forward into practice at all. It was just something we did.

DT: It sounds like as pharmacy students, you worked together a lot during your education.

LA: We did. We were a small group to begin with, so we did things together. Then there were, of course, always smaller groups. We had two fraternities and then a sorority, which is now a fraternity. My class re-activated the Kappa Psi fraternity when we were here. Bruce [Benson] was involved in that as well. We have a school, like a high school, annual type publication called *Pharmacopa*. We started that at that time, also. We did some kind of neat things like that. *Pharmacopa* still continues after fifty some years. Well, this is the fiftieth anniversary. It had a little bit of an activist streak and so on.

We were also close enough, I think, to the people who had come back from Korea. Some of those were recent graduates, which brings a different perspective, too. I think those kinds of students always affect the faculty. They generally don't tolerate nonsense.

DT: You mentioned that you had seven women in your class. What was your sense of how open the profession was to women when you started?

LA: It was interesting. Women dominated hospital practice at that time. I think that maybe every chief pharmacist in the hospital in the Twin Cities was a woman, at that time, certainly a majority were. When I went to work at Northwestern Hospital, I worked for the first master's degree hospital graduate out of the University. He was kind of unique because he was the first hospital pharmacy director that was a male. Of course, at that time, hospitals were also in the basements. There was probably more questioning of women's role in the consumer population than there was in the professional population. This probably still occurs. A woman pharmacist will be asked, "Can I speak to your pharmacist?" thinking that she's a technician or a clerk or something. If you talk to any woman pharmacist, they'll have stories like that; although, I think that's diminishing pretty rapidly now.

I can still remember when we had the first woman president of the American Pharmacists Association [APhA], a black woman from California [Mary Munson Runge]. We had the second woman president here in my lifetime, and that was Doris Calhoun. There was an earlier one that was long before me. I don't think it was a big issue. Certainly within my class, it was no problem.

DT: Do you have any sense why so many women went into hospital pharmacy?

LA: No, I really don't know. I suppose it's much more orderly. It's more predictable. In a way, it's safer. Of course, we didn't have robberies in drug stores back then. My perspective is that women tend to be better clinicians, more caring, all those important things. I think that may have been part of the hospital thing. They were closer to the patients. It was also that all nurses were female, so there was a lot of collegiality just by the nature of hospitals. But that's all guesswork.

DT: The other thing in the early 1960s when you would have been a student is that I wonder if you had awareness of the Congressional hearings led by Estes Kefauver into drug pricing and the business practices in the pharmaceutical industry.

LA: Actually, that started when I was still in high school in Tennessee. Estes was my senator. He was very representative of his state. He was a leader nationally in these issues. At that time, I wasn't planning to be a pharmacist, so it wasn't quite the level of interest that I might have had otherwise. It was *the* topic in papers and whatever electronic news we had, which was pretty minimal. Of course, then I got into school, and we heard about his hearings and so on, and I could say, "He was my senator." So we were aware of him. I'm trying to think what our reaction was. Boy, this is really stretching back. At that time, the relationship between the pharmaceutical manufacturers and the practice, all kinds of practice, as you point out in some of your articles, was pretty close. I remember [E. R.] Squibb [& Sons] had the "priceless ingredient" logo, and we generally believed that. All the manufacturers had huge professional relations departments, even in pharmacy. There would be a Merck [& Company] with twenty, thirty people in their pharmacy affairs department. Today, I wouldn't even lay money that they have such a department. It's changed so radically, and even for physicians it's diminished quite a bit. So at that time the relationship was good. I look back on the Kefauver hearings, and I think my reaction was why is he picking on these good people? They're doing great things for the profession, which they were. I was saying, "Where is he coming from?" He set the stage for change in public attitude towards the manufacturers, which, again, as you point out, they have been trying to finesse for years and have not been entirely successful.

DT: I'm glad that you have memories of that time. Of course, the Tennessee connection is important. Something that I had heard about Kefauver was that he had been in close discussion with the pharmacists in Tennessee and through the state association in Tennessee, he had agreed not to have pharmacy as a feature of his hearings, to keep the pharmacists and the pharmacist's fees out of the spotlight.

LA: Yes. There were virtually no chains at that time. Everything was independent and the pharmacists in Tennessee were a pretty central part of communities. If you got the pharmacists badmouthing you as an officeholder, you had some real damage control to do. It was wise on his part to do that—and, you know, the pharmacists weren't part of the issue there.

It was interesting in the context of price. When I graduated from high school in 1957, the average price of a prescription was about \$1.75. When I went into practice in 1962, I remember we went to a fee instead of a percentage markup. It was the first time I had to sell cough syrup, four ounces of cough syrup, for more than \$2.00. I thought people are *really* going to object to this. This is really excessive. But that was the perspective. Why worry about pricing and so on when a prescription was under \$2.00? Well... When I started out, my first job paid me \$10,000 a year, so that \$2.00 was a lot of money.

DT: Do you know then why there was the shift in practice from a percentage markup to charging a fee?

LA: That was led by a fellow by the name of Bill [William] Apple. He was the CEO [chief executive officer] of the American Pharmacists Association [APhA]. He was one of the real thought leaders in our profession. It was his feeling that a fee was more professional, and that markups were for a commodity, and that the pharmacist was providing a professional service on top of the commodity. He sold that to the profession. We had several state associations who were very well led, Minnesota being one of them. These state associations advocated for people to adopt the fee. He was correct that there is a professional service that's provided by the pharmacist. His mistake was not recognizing that one needs to make a profit on the product as well. So had he structured that as product cost plus a markup plus a professional fee for the service side, I think it would have been more reflective of the true value. I think we've suffered because of that for a long, long time. Today, in Minnesota, the last fee increase that pharmacists received from a managed care organization was in 1989. Costs have changed since 1989. They did that; they just established a fee and just have ridden it ever since without upward adjustment. And, in many cases have reduced the fee.

DT: If pharmacists had been able to still get a markup, then, even if the fee didn't change, as the cost of the products went up, you would get reimbursed appropriately?

LA: That's right. In pharmacy, you have to pay for the product within a week of taking delivery. You may not dispense it for a long period of time, certainly not the whole bottle. So you've got a cost. There are missed opportunity costs and a whole bunch of other stuff in there that are not accounted for in the professional fee. Then, when managed care came in, they reduced the average wholesale price by a percent, got down to your actual acquisition price, so, now, you were trading dollars plus a dollar and a quarter or even less in some cases.

DT: Has the profession tried to change that system?

LA: We can't, because then we have restraint of trade issues. We can't get together. It's one of the real failings that we have. I remember one time I even went to the Trades and Labor Union, and I said, "How about unionizing pharmacy owners?" "Oh, we can't unionize management." They said, "Why would you do that?" I said, "Because we don't control what managed care organizations pay us. We need to get together to negotiate that. That's reflected in what we can pay employees, so you do have an interest in this." But the management issue overrode it, and they weren't interested in pursuing it. We have not had the clout to negotiate those fees. You must do it on an individual basis. If you're a Walgreens or a CVS that has multiple thousands of stores, you can negotiate, because they need that kind of distribution. If you're an independent in Blackduck, Minnesota, you take it or leave it—and they'll tell you that. They'll say, "If you don't like what we pay you, then don't take our program." Well, if are negotiating with one of the large plans that is twenty percent of your clients, it's not an easy decision.

DT: So the state associations haven't been able to lobby at all?

LA: No. No. The only place you can do that is on Medicaid fees, because it's a legislative budget issue.

DT: That's really interesting. Obviously, I've studied pharmaceuticals and the history of, but I haven't fully appreciated the kind of economics of pharmacy practice.

LA: The first fee for a managed care organization in Minnesota was in, I think, 1982. That was about the time that the clinical practice really started to become recognized as a future thing that we ought to be focusing on. Well, to change a practice from a distributive to a clinical practice has some real costs attached to it. So, at the time that the practices needed R&D [research and development] money, there was none. So here we were...we realized that we needed to make these changes, and there wasn't the wherewithal to do it. A lot of people criticize pharmacists in communities, both chain and independent, for not doing more of it. They didn't have the resources to do it. I think one of the long-term failures of managed care is not fully realizing the impact they had on not only the provider groups but also, the quality of services that they provided. They never took ownership of their networks by saying, "It's in my best interest as a managed care organization to have the very best pharmacists, physicians, whatever out there. Do I as the agent of the employer bear some of that responsibility?" Maybe it's by providing continuing education. Maybe it's in what we pay them. Maybe it is even sharing our goals with providers.

I was on the Board of Directors for Physicians Health Plan [PHP], which is now Medica. I was vice chairman for eight years. At one time, I proposed to the board that the University train our medical and pharmacy and nursing providers. Our future relies on them to do a good job for our members. Because we're a not-for-profit organization, paying no taxes, we do not support the University of Minnesota and their education programs. We ought to give them annually a percentage of our net revenues," as a way to say, "We want to make sure that your graduates do the best job possible." Of course, that didn't go very far.

LA: That was a short sightedness, I think, of managed care. They were focused on one thing, and they didn't realize that they had a bigger role to play. It could have been a very positive role.

DT: Going back to the introduction of the professional fee that William Apple brought about... You mentioned that a lot of pharmacists in practice were concerned about the loss of markup. Were there efforts by practicing pharmacists to challenge Apple and have him...?

LA: Oh, yes, there were, both individually and organizationally. The National Association of Retail Druggists, NARD, which is now NCPA, National Community Pharmacy Association, fought that initially. NARD was an organization of pharmacy owners. It represented a different constituency than APhA, which was any pharmacist

regardless of where he practiced NARD fought it originally. They're a pretty conservative group. They also fought the Pharm.D. They fought the title of Pharm.D., and they fought the title of Pharmaceutical Care and a whole bunch of other things. Eventually, they come around. They're a political organization. They represent their constituency, so they do what they need to do. Yes, there were people that fought the concept of it.

I said the first fee was 1982; that's not quite correct. It came in a little earlier, in the late 1970s, and it was Blue Cross/Blue Shield that did that. They were the first ones that stopped paying a percentage of "usual and customary." Insurance was indemnity up until that time. I don't remember what they paid pharmacists. But, at the time, there was a statute on Minnesota books that said it was illegal for a pharmacist to agree to a special price to a group. Some of us thought that Blue Cross was in violation of that, but I think the people who were advocates for the fee thought, well, this is probably a good idea, and no one wanted to confront Blue Cross. Then, PHP, Medica, did it in 1982. Once managed care started to do it, then pharmacists pretty much began to follow. After all, why have two pricing structures?

DT: Going back to when you graduated, how did you decide what career path you would follow?

LA: Well, originally, I wanted to own a pharmacy. That was my goal throughout school.

I worked for Walgreens while in school because Walgreen's had a scholarship program that paid my quarterly eighty-five dollar tuition. I thought that was a pretty good deal. I had to work for them for a year or so, something like that. So I worked for Walgreens through school. I worked in the Walgreens on Ninth [Street South] and Nicollet [Avenue South in Minneapolis]. It's no longer there. At that time, chains were different. The Walgreens that I worked in and, I think, all the Walgreen stores were just big community pharmacies. The pharmacists that were on staff spent their entire career in the same pharmacy. They knew the people just like a corner drug would. So it was a really fun place to work. I was right across from the Medical Arts Building, so the physicians and other health providers were coming in all the time, and you'd talk to the doctors and dentists and all that stuff. So it was a real sense of community, and it was a positive experience.

Then, I got out of school and went in the military. When I came back, there were no openings at Walgreens, so I worked at Northwestern Hospital [in Minneapolis]. I worked there for a couple of years. Hospital practice was fun, but it was not where I wanted to spend my career.

Then, this opening came up at the State Department of Administration, and I was buying all of the educational and medical supplies for the State of Minnesota. This is pre-computers, so you had to sit there with these big spreadsheets and decide who had the best deal. I didn't stay there very long, less than a year. A couple reasons... One is that to be a bureaucrat was not my career goal. I was working part-time for a pharmacist up

in Falcon Heights, and he retired and offered me the pharmacy, which my brother and I bought. That was 1966. I stayed there for quite a while. We closed it eventually because we couldn't grow it because Group Health was in the neighborhood with its own pharmacy. Then, I had another pharmacy out in White Bear Lake, and I was there for twenty-five years. My brother ran one, and I ran the other.

I had tried all these other things and for a lot of reasons... One of them is that I wanted to test different types of work and practice. I think the hospital practice helped me a lot in community practice, because I knew what went on in the drug room of the hospital. The state purchasing helped me a lot because I knew that some people got better prices than I did, and if you were a canny negotiator, you could get some of that. That came in handy. It was also a revelation to know that these people with the priceless ingredient had different prices for their priceless ingredient all over the place.

[laughter]

LA: That was kind of a revelation. At that time, not that many pharmacists had that experience and didn't know that.

DT: When you were working at Northwestern Hospital, what was kind of the work day like for you? What were your responsibilities and roles?

LA: You'd come in in the morning and you'd have all the drug orders that had come down from the floors. You were responsible for filling those, plus replenishing emergency stocks. That was a morning job for all of that stuff. It was just high volume, a lot of injectables. If you were in community practice at that time, you did not see many injectable prescriptions—the only way you would put a drug in your body was through your mouth. There's a lot of other ways, and at the hospital, you got to consider all those ways. In the afternoons, you'd also fill orders, new admits, but you'd also relate with the medical and nursing staff when they were through with rounds. They'd stop by or you'd have lunch with them, so there was this constant interaction that made you feel like you really were a part of a team—a concept that has taken us a long time to come back to in non-hospital practice. In that sense, again, it was another community, and it was fun to relate to those people. It was a good experience, but not a lifetime experience for me.

DT: Did you find the physicians would go to you for advice on dosing?

LA: Yes, they'd do it on dosing and on which drug to use, cost issues. Which medication is the least expensive in this therapeutic category and potentials for drug interaction: if I do this, am I going to get in trouble with that? There were a lot of those questions. Northwestern Hospital, I think was one of the first pharmacies that came out of the basement. We were right off the main lobby by the ER [emergency room] and the labs, so that physicians and nurses were always walking by and would stick their head in the window and say, "I have a question." You got to know them. Throughout my career, I would run into those people that I had met at Northwestern and talk about old times and so on.

DT: It sounds like there was a lot of respect from the physicians and nurses for what you, the pharmacist, had in expertise.

LA: Yes. It was interesting, too, and we still see that today, that there is a real recognition of the value of pharmacists institutionally, but that same physician can go out to the community and not feel that same confidence in what the pharmacist on the corner is going to tell him—unless they have an established relationship. But, just to call up *a* pharmacy and ask for *a* pharmacist and respect the judgment of that person is really a stretch. I can understand it because relationships are important. I think there was a certain amount of credibility that came with just working in a hospital. Today, there is still a distinction made that physicians will say, “I talked to my Pharm.D...” That person on the corner may be a B.S. [Bachelor of Science] graduate. So there’s a distinction.

DT: Did Northwestern have a formulary?

LA: No, not a formalized formulary. We would put out that this is the product we’re using and so on, but there was no requirement to prescribe it. At that time, we still couldn’t make generic interchanges; although, we did in the hospital but you couldn’t in the community. That didn’t come around until 1975 or something like that. So a physician who was very comfortable with a generic interchange in the hospital would go ballistic if you did it out in the community. I never did understand that, and I still don’t understand that.

DT: I have some more questions about that in a short while.

Were you providing information to patients about the drugs they were taking?

LA: Not in the hospital. I suppose occasionally you did, but it wasn’t a routine thing. At that time at Northwestern, we did not round, and we didn’t talk directly to patients. It was through the nursing staff or the medical staff.

DT: When you were working for the state, was there any formulary used then in what drugs you could buy?

LA: Not that I remember. I think it was just what anybody ordered. We would purchase for the state hospitals, and they had a limited number of drugs that they used depending on their patient population, so, in effect, there was a formulary. It wasn’t everything that was available. That was mostly because the physician, staff said, “These are the meds we use. We don’t care about the rest of them.”

DT: Your experience at Walgreens... As you mentioned, it’s a chain and that’s quite different from owning your own pharmacy, and it’s different from hospital pharmacy. Can you articulate what you saw as the main differences?

LA: Well, I was an employee at Walgreens, and I *owned* my own pharmacy. That in itself is the distinction. But in a corporate environment, you adhere to policy. In an independent, even if you don't own it, there's a very flexible policy, and it's what the patient needs trumps others concerns. That's not *always* the case in a corporate practice. Which health plan that you choose to participate with was a business decision. In the community practice, you tended to take them all. In a chain, you did not—do not, as we saw with Walgreens and Express Scripts recent contract issues. I think it's different in a chain today, because, as I pointed out, in those days, a pharmacist stayed in the same outlet for virtually a career. That's not true today. There's a lot of churning, and it's harder to really develop the relationships; although, there's still some of that, but I don't think it's as frequent. I think in a chain there's less of a feeling as a pharmacist that you have individual responsibility for this patient's outcomes. I don't think you feel that. I know you don't feel it with mail order dispensing. When you're in the community, because you've known not only this generation but probably two previous generations of the same family, there's a real feeling of responsibility for these [customers] as people. I think it's a big difference. I'm not so sure that our graduates today really appreciate that: the responsibility of being responsible. I think a lot of the social media is changing that as well. If you never look somebody in the eye, it's very easy to not feel responsible. I think those are changes that need to be recognized. In an independent community practice you're much more able to be innovative because you don't have corporate policy to contend with. If you see a need, you can fill it. If it doesn't work, you abandon it, and if it does work, you grow it. That's one of the thrills of independent practice. You can walk into a physician's office and establish a working relationship and decide that we want to have a collaborative practice agreement and you're free to do that. I don't think that would be the case in many chains. You're restricted on that.

DT: That's interesting. This leads me to another question. When you and your brother purchased the practice in Falcon Heights... I was going to ask what the major challenges were in setting up a practice or at least taking over a practice, but you bring up the issue of meeting with physicians and kind of collaborative practice. Can you talk about that, how as an independent pharmacist you would build relations in the community?

LA: Yes, in a number of ways. Independent community pharmacies hire people in the neighborhood. That's one way to do it so that you develop that relationship with members of the community. We were probably one of the principal employers for first-time job seekers, the sixteen-year-olds. As Harvard says, "It's that first employment experience that will determine your life as an employee." So you do that. Then, you call on physicians' offices. All physicians, at the time we started, were independent practitioners, anywhere from one to half a dozen docs in a building. You go up, and you talk to them, and you work with them. You develop a level of trust, bi-directional. So you work together. Even though we didn't have collaborative practice at that time, it resulted in physicians saying, "During hay-fever season, rather than me writing all these prescriptions until I find one that works; let's put together a list of products that you can use. I'll just send them down to you and you just work your way down the list and dispense a week's worth until you find one that works and, then, we'll go with that." So you could do that sort of thing. I also was on the Board at Saint John's Hospital [in

Maplewood], so I would develop relationships there with the medical staff members who overlapped my practice area. I would see them at board meetings and then work with them on patients later. We had common experiences, so it worked well together. I think a lot of community pharmacists do those sorts of things. They may be on school boards, they may be on city councils, and they're part of the community. They wouldn't call themselves leaders, but, in fact, they are. I think that's something that probably chain pharmacies choose not to do. Chain pharmacists are treated, and think of themselves as forty-hour-a-week people. That's a difference.

DT: Were you prepared to do that based on what you'd been taught in college or did your brother have that experience or do you just figure out by doing how to make those contacts?

LA: I figured it out by on the job training. You realized that you needed to do that. My brother was more extroverted than I was, so he let me do all of that.

LA: I enjoyed it, so it worked out fine.

DT: You mentioned earlier about the kind of absence of the patient in your education here. In talking about building relationships with the physicians, I'm curious, say in the 1960s and even in the 1970s, did you find that physicians essentially chose for their patients what pharmacy they would go to by kind of encouraging them to go to a pharmacy or did patients go to whatever pharmacy they wanted to?

LA: I think they went to whatever they wanted to; although, they tended to go to the one in the neighborhood, unless there was some reason not to. Did physicians recommend? I think they did. In the case for antihistamines for hay fever, "Why don't you go down and see Lowell. He'll take care of you on this," which is a recommendation. We see the importance of that today in medication management that it works best if the physicians endorse the service. It's one of the real challenges for us: how to get that endorsement to happen. I think it's important for a physician to say, "Go see Lowell," versus "Go see your pharmacist." There's an implicit recommendation there, because they know a name. That's helpful.

DT: What were some of the other challenges that you encountered in setting up the practice?

LA: The margins were, I'd say... When we went into it, they were pretty good and costs were pretty low. I got into my own practice in 1966.

The first Target store opened in Roseville in, I think, 1961 or 1962—bad planning on my part—this brand new concept, you know. Target had a pharmacy up there, and it was the first pharmacy in the first Target, and it was a group of [University of] Minnesota graduates who started that. Price had never been a factor before. So they started talking price. That, then, caused a lot of competitive concerns. The first big product that was promoted on price was birth control pills. They were selling for \$1.49 a cycle, which I

always thought was crazy. That started a recognition that prescriptions are cheaper at Target, so how does an independent confront that?

In the early 1970s then, you begin to see managed care coming in and they started to, essentially, put a ceiling on price, so how do you manage that? You couldn't manage your cost. You still had to pay the electric bill at a rate established by the electric company. You had to pay your employees a competitive wage that was community determined. But you had a ceiling on your price set by managed care. It was a real challenge. We had Group Health in our neighborhood. Do you know where Falcon Heights is?

DT: Yes.

LA: Ours was a big University community and Group Health was, at that time, the University health plan. So a lot of the people went down to the Group Health for both medical and pharmacy. That was a competitive thing that was just impossible to manage. When I first opened in 1966, there were twelve independent pharmacies on Snelling Avenue [in Saint Paul]. Today, there are two. That's a result of these changes and how difficult it is to survive.

We were not computerized. We still used typewriters. We were the first pharmacy in the state, that I know of, that put in patient records of all the prescriptions that somebody got. We kept that for many years. At the first of the year, we sent out photocopies of this for tax purposes. It was kind of fun, because all of the students who worked for us would come back from college and on New Year's Day, we'd bring in food from the deli, and they would sit there and run the photocopier and stuff the envelopes and stamp them, and we'd put them in the mail and send them out. It was a big party for the kids and on January third, the people had their tax record. That was pretty good.

A little bit later. We were the first pharmacy to give public notice for discontinuing sales of cigarettes. It was a slow news day, so the *Saint Paul Pioneer Press* had a picture of me taking cigarettes off the shelf, above the fold in full color. It would never have occurred had there been something of note happening, but that story got picked up internationally. I remember that I got a call from a paper in North Carolina. Jesse Helms was a Senator from North Carolina. He was a big supporter of the tobacco industry. The reporter said, "Do you mind doing an interview, because I don't think our senator can get at you up there?" Our action was real positive for our practice. My brother and I felt it was really strange that we take care of their health problems in the back of the store, and we cause them in the front of the store. For decades, literally decades after that, I could meet a person at a party, and they'd say, "Oh, you're the pharmacy that quit selling cigarettes." For public recognition to last that long for a *positive* thing, I think is really unusual. That brought people in. People would say, "I read your story. That's the kind of people we want to support that will do this. This has got to cost you a lot of money and you're willing to give up those profits in order to do this."

That's part of the public health opportunities I think that pharmacists have. I don't think we do a good enough job of addressing those things. But, you know, people do it here and there and get some recognition for it. Those are the ways you insinuate yourself into your community. You have to see yourself as part of the community, not just providing medication for the community. You really are a part of it, and your interests are their interests. That's just the beauty of it.

DT: I imagine that it's easier to do in a small town than it is in the metro area.

LA: Yes, it is, but it's not hard unless you're downtown on Ninth and Nicollet. Well, even there, we had a community. If you're in a suburb, it is a small town. People walk to the pharmacy and so on.

DT: It's interesting that you mentioned that your biggest competition was from Target. I wonder...chains like Walgreens and CVS, did they function as big competitors for you?

LA: They didn't at that time. CVS wasn't here at that time. Walgreens was. Walgreens had a store downtown in Minneapolis and one in Saint Paul and there were probably a couple others. They were just big independents, the way they functioned. They weren't competitors in that sense. It was the Target that changed the merchandizing philosophy that now says prices were important and then service. That's been continued with the likes of CVS and Wal-Mart. Prescriptions have become commoditized in our society. The chains aren't responsible for all of that—it is really a cultural change. We don't think of prescriptions as therapeutic agents as much as just something you have to buy, and they cost money. Employers certainly think that way. A drug benefit is something you have to include in the benefit package. Who cares if they work?

DT: It seems to coincide with Kefauver's hearings. As you said, they brought prescription drug costs into the spotlight and that coincides with the arrival of the big grocery store chains that were also doing pharmacy like Target.

LA: That was the time, too, that it was called the "Pill Bill," I believe. Prior to that, probably about the mid-1970s, only pharmacies could sell over-the-counter meds. Then it was changed so that anybody can sell them, which, again, added to that image that this is just another product.

DT: That arrival of the big grocery chains, like Target, coincided also with changes in the way that pharmacy was practiced, if I understand it. There was less compounding and much more distribution of packaged drugs.

LA: Yes, that's true.

DT: That also would presumably put the pharmacist in a dilemma in how to distinguish themselves.

LA: I don't know when it occurred but in our statutes, pharmacists were required to compound if called upon to do it, but a lot of those big-box stores would say, "We don't have the material to make that, so why don't you go down the street to the corner pharmacy. They can do that for you."

DT: That was a nice niche.

LA: It was. We did a lot of that at the Walgreens store I interned at because we had a big dermatology clinic across the street, so we were always compounding. I could come in on a Sunday and make ten pounds of hydrocortisone ointment. When I had my own practice, ten pounds would have lasted my entire career.

[laughter]

LA: We used to buy cortisone powder in big aluminum cans. I still have one that I put my change in.

DT: [laughter]

You mentioned a little while ago the issue of substituting generic drugs for brand name and generic interchangeability. That was, obviously, a big issue lesser with Kefauver but with Gaylord Nelson's hearings in the mid 1960s onwards. Can you talk a bit more about kind of your position as a pharmacist on generic substitution and some of the debates that affected you?

LA: Yes. Because of my hospital experience, I had probably a different comfort level with using generic products than some of my colleagues who had not had that experience. I was active in our national association at the time, as well as the state association. So, politically, I understood that this was a real opportunity for pharmacists. Being somewhat of a politician, I understood the benefits to that. Again, the American Pharmacists Association, then called the American Pharmaceutical Association, saw that as an opportunity for pharmacists to expand their clinical expertise into making these judgments. There were a limited number of generics. The manufacturers were pretty reputable. We didn't really focus on that at the time. There was no importation. It was all domestic.

But the physicians really fought it. The physicians individually did not fight it, but when you get two or more physicians together, they change and, then, this collegiality overrides rational thinking at times. So the physician organizations fought it. The Minnesota Medical Association fought it. The AMA [American Medical Association] fought it. They just thought this was terrible. There was a speech by the president of AMA that pharmacists will do no prescribing. The physicians will do no dispensing, something like that. So there was this real feeling that we were involving ourselves in choosing the product.

I think it only changed, again, when managed care came in and mandated generics. When the law passed it required the use of generics in Minnesota, and that's probably national now, so you have to use the least expensive equivalent product. In 1982, PHP put in the first formulary for independent practice association physicians. There had been formularies for a group health, but there were not for open networks. In that first formulary the pharmacists could not only make a generic exchange, but they could also make a therapeutic exchange. If antibiotic A is not covered, you use an equivalent one that's different chemically, and you can make that exchange. The expectation was you then advised the prescriber of that change. PHP also penalized the physician if they wrote off formulary. If seven or more more non-formulary drugs were prescribed in a two-week check write, they would bill the physician back for the entire number of prescriptions that were non-formulary. Well, that quickly got like ninety-five percent compliance. That health plan recognized that pharmacists could go further, even than generic; they can do therapeutic. They've since rolled that back and haven't done it for a number of years. When that first started, you felt compelled to call the doctor and say, "I can't use a brand name. I have to use this generic," which eats up everybody's time. Finally, they just gave up and said, "Do what you've got to do." It was and it still is a problem with many consumers. "My doctor prescribed that, and I want that. I don't want the generic!" Differential co-pays have changed a lot of that resistance. If we to a patient: "If you take the generic, it's \$10, but if you take the brand, it's \$50. What do you want to do?" The answer is different. I think over time generics have become a non-issue. About eighty percent of the prescriptions, or thereabouts, are dispensed as generics now. I think that's good. It certainly held the escalation of drug costs down.

DT: Were you ever concerned about bioequivalence?

DT: Yes, I was. When I first started doing it, I would keep in my file information that supported my decision to use a particular manufacturer's product, expecting, at some point, to have somebody challenge me or that I'd need the information to find out why something didn't work. I was never called on to do it and, after a while, it just got to be too big a chore.

It's one of the issues... We'll probably get into this later. The nation's drug supply is really a crapshoot. The identity of the manufacturer of a generic product or a branded product is a concern for me, as a lot of them are farmed out to manufacturers in other countries. It is very difficult for a pharmacist or a physician to find that information. Then, of course, consumers' Internet purchases and those medications' pedigree are a public health issue.

DT: Did you have, in the first decade or so, in practice particular manufacturers that you felt more comfortable using either their brand or generic?

LA: It was interesting that Geneva [Pharmaceuticals] generics was the first one in this market that made a huge impact. They did it for several reasons. One is that they were a reputable company. They were out of Colorado. They were, subsequently, purchased by one of the branded companies [Sandoz, Inc.]. They really worked the quality of their

products, and they would detail physicians, which is now, I think, unheard of for a generic house, so physicians became familiar with it. We also, at that time when I was at the health plan, decided to contract with one generic companies. We put out an RFP [request for proposal], and Geneva got that contract. It made this particular market area the leading market area for Geneva generics for a number of years to come. It also caused pharmacists, generally, to make Geneva their preferred manufacturer for generics. The result was that it made the number-one generic manufacturer in this market, a quality I think that was very good strategically for all concerned: patient, provider, plan and manufacturer. It is interesting that some of the other generic houses wouldn't respond to our RFP. They were back hat-in-the-hand very quickly when they saw the shifts in market shares of their products.

DT: Do you think things changed to any extent in terms of the generic market when the Hatch-Waxman Act was passed in 1984?

LA: With the rebate program?

DT: Yes.

LA: It probably did in public programs, but I didn't sense any big change then in independent practice. It really started driving a new revenue stream for managed care and PBMs [Pharmacy Benefit Manager] with the rebate program. Those rebates, I think, eventually got up to like thirty, thirty-five percent of the cost of the med on average. This is huge amount of money and was never shared with the employer or member, in spite of assertions that it was. I think pharmacy practice and physicians generally knew that there was a driving force for the selection of certain products. The state, of course, had rebates also, but they were so far behind in collecting them that I don't know if they ever got them all.

DT: On the issue of bioequivalence... The FDA [Food and Drug Administration] was starting to expect generic manufacturers to provide bioequivalence or bioavailability data in the 1970s. Then, they established the *Orange Book*, I think around 1978.

LA: Yes.

DT: Were you aware of what the FDA was doing? Were you using the *Orange Book*?

LA: We did for a while, but it got too hard to manage. We, as I think everyone else did, decided, well, that's a judgment that we're really not capable of making, because a lot of the generic products that you would get would be determined by your wholesaler. You could order brand A of generic, and if they had recently negotiated a price with manufacturer B, then that's what you would get. It's still a problem today, because yesterday you got a pink pill, and today, it's a blue pill. How do you explain that to patients? There are some real issues in that with the loss of control at the local level. Price is such a huge factor in health care generally and, certainly in pharmacy that you go with the flow.

DT: Going back to the Minnesota law that made, basically, substitution legal and a requirement... Did the [Minnesota] State Pharmacy Association and the Board of Pharmacy play a big role in getting that through?

LA: Yes. Actually, they were the movers, and they got the legislation. They got the authors and so on. Of course, saving money for voters was an easy political issue for members of the Legislature. Yes, that went through. They left the decision up to the professional judgment of the pharmacists, which was kind of an important issue. So, yes, the association and the board. I was on the board from 1969 to 1974. We had talked about it but it really didn't get passed until later.

DT: You mentioned that, obviously, organized medicine, particularly the Minnesota State Medical Association and then the AMA, were really opposed to this. Usually, organized medicine is pretty powerful, so why was the pharmacy position much clearer to the Legislature?

LA: One sidebar on that is there's a case where medicine and the manufacturers were very close. They were, essentially, the stalking horse for the manufacturers. But, I think the pharmacists issue was compelling in that this is going to reduce costs when it is the identical product. Talk as much as they wanted about that it's not the same product, in fact it is. We could demonstrate that branded manufacturers owned generic companies. I think we had the best argument, and we were on the side of the consumer. It was not really a pharmacy issue, because, at that time, still much of the pharmacy product was on a percentage markup. So, actually that was a negative economic factor for a lot of pharmacies. But we did this because we thought it would help the consumer. I think it was one of those nice times when you were on the right side.

DT: Were there actual specific consumer or patient groups that were also mobilized?

LA: Yes. The Senior Federation was on our side on that. We worked very closely with them at that time. My recollection is that they were the biggest group and, of course, they're very influential. We haven't always seen eye-to-eye but in this case, we did.

DT: I imagine having worked for the state, that the Department of Health or Welfare, whatever it was called at that time, was pretty onboard with this, too?

LA: Yes. The DHS [Department of Health Services] with the Medicaid program—it was called welfare then—was onboard because they saw a benefit to its budget.

I don't know where the insurance industry was on that issue. I just don't remember any real activity on their part. There may have been; I don't know. I think drugs at that time were such a small part of their budget that it probably wasn't a big deal.

DT: I've been looking nationally for the health insurance industry in the 1960s and 1970s on drug politics, and I haven't found it. Maybe it just isn't there because it wasn't a big issue in their cost.

LA: Yes. It's too bad, because they were drivers of cost, because they paid prevailing charges.

You mentioned oral contraceptives earlier. Another substantial change, potentially, for pharmacy practice in the 1970s was the introduction of the patient package insert.

LA: Yes.

DT: Did that change things for you?

LA: As far as just providing information? In my practice, we provided the patient with the product insert that was not written for the laity. We did that partly for transparency. Partly as a little bit of rebellion, because we were told by the board that we shouldn't do that. We argued that our patients were pretty smart. When computers came in, they would also begin to print out patient information that was drug specific. It was not always accurate, but it was better than nothing at all. There was really a mixed patient acceptance of that. Some of it was, "My doctor told me everything I need to know." You had to be judicious because the professional package insert had all the side effects, and there are patients who will get every side effect that's listed. So you're careful with that. Occasionally, you'd get a physician who was upset, "Why did you give my patient that? I'm not using it for what it's marketed for." Those were concerns. They were circumventable if the physician would have told us what the purpose of the prescription was.

In 1981, there was a big battle between pharmacy and medicine as to who was going to provide these packages, these patient inserts. Medicine thought it was their responsibility. We thought it was ours. That was negotiated nationally. I don't know if AMA ever launched theirs or not. I know we did ours. Of course, now with the Internet, it's pretty moot.

DT: There were discussions, I think from the late 1960s, that Gaylord Nelson was pushing for a national drug compendium to do away with the product inserts and have every physician, and presumably pharmacists, given a national drug compendium that would...

LA: Would be printed out and given it to the patient and so on. We fought that, recognizing the individual needs of patients. We also didn't think that it was the government's responsibility to do that. It was a professional responsibility, which I think is correct. If you look at the FDA mandated package insert, if that would have been the model for what was going to go into this compendium, it would have served very few interests other than the staff of the FDA. There was a battle on it. I'm kind of glad it turned out the way it did. I still don't think that our software people really have taken

advantages of the customization of information based on a patient's total drug usage. It's one product's information if you're only taking one prescription, but if you're taking two, it can change it. How do you accommodate that? Maybe that's the role of pharmacists, and maybe it can't be done in print. Maybe that's MTM [Medication Therapy Management]. Well, it is MTM.

DT: I know we've touched upon this before about whether the patient expects to get their advice on drugs from the physician or the pharmacist. When you were practicing in Falcon Heights and then in White Bear Lake, did you notice any change in patients' attitudes towards going to you, the pharmacist, for advice versus trusting their physician?

LA: A change over time?

DT: Yes.

LA: Yes, but I don't know why. Was it that they got to know me better? I'd been there longer? Or was it because of changes in relationships with physicians, or was it changes in consumer attitudes that they generally recognized the education of a pharmacist? I don't know what the cause was, but, yes, overtime there were changes in that. We always had people who would say, "Well, you know more than doctors about drugs." All pharmacists have had that experience. That's not necessarily true in all cases. I think it helped that with pharmacists one didn't need an appointment. Also, one didn't get a bill. You could come in, and you could ask a very focused question and get a workable answer without a lot of involvement, scheduling, and so on. I think that grew the recognition that the pharmacists were a good drug information resource. I think that recognition has continued to grow over time. One of community practices' strengths is that we're in virtually every community, and we're accessible fifteen hours a day and a pharmacist is always in the pharmacy. That's a real value to a community.

DT: As your practice grew, did you hire more pharmacists or were you the sole pharmacist?

LA: No, we added more pharmacists and more technicians as we grew.

DT: When you were in practice in the 1960s and the 1970s, and I guess the 1980s, too, how close were your ties with the College?

LA: They were always close. I've served on and led committees in the College my entire career and was adjunct here for years. I've served on Academic Health Center committees, advisory committees for a decade in the 1970s or 1980s. Dean Weaver named me as an advisor to the dean, an official title, which I don't think has ever been replicated.

LA: There's a lot of reasons for my ongoing involvement with the college. One is I'm supportive of the College and professional education in general. Also, my activities

professionally, both domestically and internationally were beneficial to the College. There were ways that I could help the College or its faculty members, which I was willing to do. Certainly, I took students in my practice for most of my career. It was a good relationship, and I had a good relationship with every dean, except the one that was dean when I was in school. He never did figure out what my name was.

[laughter]

LA: But he's dead and I'm not. It's been a real strong relationship.

I left practice in 2006. I promised to never practice under Medicare Part D. I was on our national association board at the time that Part D legislation was going through the Congress. Our lobbyist would come back and report on what was happening in Part D. At one of her reports, we did an around-the-table response, reaction. I was last, and I said, "I'm going to leave practice." "Why is that?" Well, pharmacy really thought that the inclusion of MTM in that benefit was a real plus—and to a degree it was. But it was going to be farmed out to the PBM industry. Having been involved with that industry, I knew exactly what was going to happen. In fact, it did. Almost eighty percent of the PDPs [Prescription Drug Plans] don't allow community pharmacists to provide MTM services and those who do provide a pretty basic compensation. I said, "That's just not where I want to do in my profession." So I left practice the first of January 2006.

The Dean and I had discussed leadership and college for several years. As a result I was invited to start the Center for Leading Health Care Change. So it continues to be a close relationship.

DT: Just to follow up on your comment about Medicare Part D... The MTM, the Medication Therapy Management, was basically farmed out to the Pharmacy Benefit Managers. Can you talk a little bit about the emergence of these PBMs and what function they play in the pharmacy world?

LS: They started out as claims processors—pure and simple. Originally, it was paper claims process. PCS [AdvancePCS, Pharmaceutical Card System] out of Arizona was, I think, one of the first big national ones. When I left practice I still had in my files my original contract signed by the founder CEO of PCS, who was a friend of mine at the time. So, they started out as claims processors. We sent in paper claims, and they sent us a check. Then, in 1981 or 1982, PHP put computer terminals in every one of pharmacies in its network. This allowed the pharmacist to submit claims online, and we were able to tell if it was an acceptable claim real time. Following that, we went to electronic claims processing.

Then, they realized, correctly, that processing claims was not a big enough revenue stream. There was a need to have other products, and there were other needs by the payer. PBMs found that they could play a role in reducing the drug benefit costs. They unbundled the cost elements of the prescription. One element is the cost of the product. The other side is the cost of the pharmacist's service. They separated them and addressed

those costs independent of each other. This enabled the rebate concept on the cost side and facilitated formularies, which are rebate cost driven. They got into formulary management as a separate business line. Then, they controlled the cost on the dispensing side by reducing the pharmacist's fees. It was a very wise decision

They also got into research. They had this *huge* room full of data. I remember United Health Care people told me once, "We never have to have another member. We can live forever off of our data...slicing, dicing data." So that was a big revenue stream for them also.

They started out very simply, and eventually they controlled the drug use patterns in the United States. Their formularies initially were regional formularies, and now they've expanded to national formularies, which is a little bit disconcerting, because health care is local to a degree. They have a very close relationship with the manufacturers and with the chains. Chains get a better shake on fees than independents do. But the problem going forward for them is, what will their role in the future be? Does an ACO [Accountable Care Organization] need a PBM? If you're an ACO that has a geographic market area in northern Minnesota, maybe you don't need all of these meds, and you don't need a formulary that's as extensive as a national formulary would be. The ACO may just hire somebody to make a regional formulary based on our patient use? The ACO may be able to do its own negotiating for rebates. I think PBMs are in a real difficult position right now as to what are they going to do going forward. Are they going to revert to just claims processors? There's an argument to be made for that as it is a strong niche for them to fill. Essentially, they haven't had a new product for a decade. They have been milking a very profitable business line for years.

DT: If I have this right then, they originally started as claims processors because health insurance companies basically outsourced to them to manage the claims that pharmacists were submitting?

LA: Actually, PCS started as a stand-alone. Diversified Pharmacy Services [DPS] was a spin off from United Health Care that they developed for their own internal purposes and, then, saw that it had marketability and spun it off. PCS merged with Caremark [RX]. Caremark then merged with CVS. In the interim, Eli Lilly bought PCS and lost a huge bucket of money, and [Glaxo]SmithKline bought DPS and lost another whole bucket of money. They tried that kind of integration. So now the retail pharmacy/claims-processing integration seems to have a little bit more longevity than the manufacturer/PBM mergers did.

DT: That's such a massive minefield.

LA: Yes. When Eli Lilly bought PCS, I think their price was \$40 million, which is chicken feed today. What did Medco just get purchased for?

That's the latest thing. Culture trumps everything. You have Express Scripts who is culturally deficient, and you have Medco who has been a very big supporter of quality

care and has been very innovative. Now, Express Scripts owns Medco, and you've seen a whole lot of really competent executive level people, many of them pharmacists, let go. They've abandoned their international emphasis that Medco had put together within the union. I think a lot of those very progressive programs will just disappear, because that's not Express Scripts' interest. There's where a bad culture can overrun a good culture. I think it will be a negative effect on the drug benefit.

DT: With the Medicare Part D and with the PBMs being given primary responsibility for Medication Therapy Management, the PBMs are more oriented towards costs savings rather than actually looking at what the patient might need?

LA: Yes. Product interchange... Let's get you off drug A and put you on drug B. It's all done telephonically. Whether that's good or bad is still undecided. But there's no individual pharmacist responsibility for any of these patients. It's just a call center. But it is mostly product movement. I don't think it rises to the level of Medication Therapy Management. I think it's something else, but it meets CMS's [Centers for Medicare and Medicaid Services] standard, which is probably pretty poor.

DT: Going back to your long association with the College and your long tenure as an adjunct professor here, you must have great insights into the changes that were taking place within the College. I'd like to ask you more about that. You mentioned earlier, briefly, about Larry Weaver's introduction of clinical pharmacy. I wonder if you might speak a bit more about his introduction of clinical pharmacy here and what that meant for the College and what it meant from your perspective for the State Pharmacy.

LA: To put this in a little bit of perspective... The clinical movement started in California. There was a man out there by the name of Don [Donald] Brodie, a professor at Southern Cal [University of Southern California]. He came up with this concept of clinical pharmacy. I don't know if he was first, but he was the first national person that was seen as an advocate of that. He started graduating clinical pharmacists. They were well received in, primarily, institutional practice and in academics. He kind of caught the eye, I think, of academics generally, as a new idea. Then, schools started doing add-on Pharm.D. programs – one or two years after the BS in Pharmacy degree. Minnesota had this at one time.

There began a whole movement called clinical pharmacy. Their association is the American College of Clinical Pharmacy, ACCP. Those were people who primarily worked in institutional practice and who were consultants to the physician staff. They didn't work directly with patients. That was only a side relationship. They were not elitists but they were removed from the center of pharmacy, nationally. Then, as the numbers continued to grow, for a long time there was argument about, "Well, I was one of the *real* Pharm.D.s. I wasn't an add-on, which is not a *real* Pharm.D. There was this distinction, mostly in their own minds. Then, the colleges started to say, "Well, maybe we ought to really integrate more clinical courses. This is a future for the profession. The association of professional societies said, "Yes, we agree with that." It was very supportive.

[break in interview]

LA: When Larry came here, he began to advocate for the inclusion of clinical courses into the curriculum. He got that through in, gosh, I don't know, the early 1970s maybe.

DT: Nineteen sixty-nine, I think.

LA: It was. Okay.

So then, there was an add-on also, add-on Pharm.D. Then, the discussion came about, "Should we have a Pharm.D. program?" I was on the accrediting council at this time, ACPE, American Council for Pharmaceutical Education. We were writing standards for the Pharm.D. program. The way that organization is structured is that there's three sponsoring organizations: the American Pharmacists Association, the National Association of Boards of Pharmacy, and the American Association of Colleges of Pharmacy [AACCP]. Those were three equal supporters of ACPE. The way the organization did and still does major policy changes is that it has to have the concurrence of all three organizations, not just a majority.

So it went to the APhA's House of Delegates and it was approved. It went to the National Association of Boards of Pharmacy House of Delegates and it was approved. It went to AACCP, and it was voted down. Colleges didn't want Pharm.D. I think it was two years later they finally came on board, and approved it.

Larry had a retreat out at the Freshwater Institute in Minneapolis and the faculty and profession debated the all Pharm.D. I debated the pro side, and Pat [Patrick] Hanna, one of our faculty members, who just retired, was on the con. After a lengthy discussion the faculty approved the all Pharm.D. program.

I don't know when it actually came on board here. Do you have that in your...?

DT: I think it wasn't until the later 1980s, even though it was...

LA: It was approved earlier.

DT: Yes, in the early 1980s.

LA: You have that whole curriculum development program, which is weird.

So I think we were one of the first half dozen schools or so to do an all Pharm.D. program, and that was Larry Weaver's leadership that did that.

DT: Why was the American Association of Colleges of Pharmacy opposed to an all Pharm.D.?

LA: I really don't know. I wasn't at that meeting. I was at the other two. I suspect that at that time, the AACCP was still dominated by the basic sciences and not the clinical faculty who were all junior. The big debate there was whether a Pharm.D. could even be on a tenured track or be promoted within. I was on a search committee for Marilyn Speedie, our dean now, and the debate was can a Pharm.D. be a dean? That was sixteen years ago. There was a lot of that. The old basic scientists are pretty strong, and even the chemists here vetoed... One dean that came through the process was accepted and was here looking for a house. The basic scientists went to the Legislature and got the candidate to pull out. I don't think that would occur today.

DT: How long ago was that?

LA: It was sixteen years ago. It was really a strange series of events. The candidate had been a graduate dean at a state university. He had said that in his school all Ph.D. theses were marked up for appropriate grammar and spelling and so on. This group of basic scientists thought it really impertinent to do that. They didn't want anything to do with him as a dean, if that's the way he looked at life. I think the candidate was correct.

Those were the stories that I heard. I think they are credible

DT: How is it that the basic scientists in the College could have had that much influence with the Legislature?

LA: They were pretty senior, and they spoke to a legislator. All it took was for the legislator to call our candidate and say, "We're having some pushback from your faculty." I think he was wise to make the decision he made. Why start out in a hole?

DT: In bringing up the basic sciences, it seems there could have been... Within the College of Pharmacy that there were basic scientists and then there were professional pharmacists focused on professional education. Those seem like quite different sets of priorities, focuses. How has that impacted the College? Have there been divisions?

LA: There will be divisions and, yes, there are divisions. I think, however, that generally our departments that are what we call basic science understand the mission of pharmacy. They may not understand or even, in some cases, really be interested in how a pharmacist in the community delivers service. They understand the value of their discipline to the pharmacist in practice. That understanding is sufficient in my mind. They can relate their coursework to a person who is going to be a practitioner. That's their role. Science is the underpinning of pharmacy and if we don't have those people, then I think that we would suffer a lot. They're vital to our mission of patient care.

[break in the interview]

LA: Yes, they fight for their department, and they fight for their discipline. So what? So does this department. The beauty of academics is that you're able to fight for what you believe in—and not lose your job.

[laughter]

DT: Of course, there's a parallel situation in the Medical School and the Nursing School increasingly, that those who are doing primarily research versus those who are educating or focused on training students for practice versus research. So I suppose within Pharmacy, it's no different from the other health sciences.

LA: Exactly. I think that there is an opportunity here, and this goes across the Academic Health Center [AHC], for those schools that have practitioners where they actually have patient responsibility. There is practice-based research going on in all of those schools. I think that the failure of academic research is that it only has value if it's published in a peer-reviewed journal. If we're really trying to advance the quality of health care in this country, there's a lot of research that's done that doesn't rise to that level, but would be very valuable for all types of practitioners. I think that we overlook the value of just a one-pager; we discovered this, and it may have value to you in your medical, pharmacy, dental practice, whatever that is. It could be an economic issue, a practice management issue, or it could be a clinical issue. It doesn't have to be peer-reviewed to have value. I think that's a failure in the thinking of academic health sciences people, because that could make a big difference in the quality of care that is delivered.

DT: I'm glad you mentioned dental pharmacy. I'm curious about... When I think about pharmacy, I think about the physician/patient relationship, but, of course, there's veterinary drugs as well as drugs that dentists primarily use. What's your sense of how relationships have been with the College toward the School of Dentistry and maybe the College of Vet Med? Has there been much overlapping training or education?

LA: No, not a lot; although there is some real nice work being done now between Pharmacy and Vet Med using animals as a model for how drugs respond and so on. I don't know any more about it than that, but I know it's kind of landmark research.

Again, I think that is one of the opportunities of the Academic Health Center that is overlooked, and it goes back to a 1996 report that was commissioned by Frank Cerra when he was provost. It was about interdisciplinary education, and the value of teams. It was a good report. There's people working on it still, but that report was fifteen years ago. It still really isn't operational—we're still planning.

My observation is that the six schools in the Academic Health Center have varying degrees of relationship. Some of them are pretty close. I think Medicine and Pharmacy are pretty close. Dentistry is a little bit more removed. Public Health, which should be vital to all the other five, seems to be off by themselves. Our people, I've been told, can't even take courses over there without paying additional tuition. There needs to be some leadership that steps up and says, "That's wrong. Fix it." I think that going forward, the demands on health providers is that there really be an interdisciplinary attitude that includes public health—that promotes population health as critical to the other five. We're not seeing it, and I think that's a shame.

DT: I know that originally one of the arguments for reorganizing the health sciences in the late 1960s, early 1970s was to promote this team teaching, team practice concept.

LA: Yes. Yes, and I don't see a lot of it. Maybe it's going to take pull from the market to say, "We demand it." The ACOs are going to demand it, as are health homes. Then, they'll start to do it because now the alumni will come back and say, "You didn't tell me how to do this." Sometimes, you have to rely on that.

DT: I think it was Bob [Robert] Cipolle who was telling me in those early years of the Pharm.D. program, when it was so small, that the Pharm.D. students were taking the same courses as the medical students in their first year or two, the basic science courses.

LA: Yes, I'd heard that as well. That's kind of cool...

DT: Yes.

LA: ...for a number of reasons.

DT: That's an example of what the AHC was supposed to be. Then, of course, as the Pharm.D. program got bigger, there wasn't room in the Medical School classes, so the College got its own classes.

LA: Yes. I just think that all of those professional programs are going to need to be rethought. You're starting to see questions of why does a physician need that much education for primary care or something. I think those are good questions. They're public policy debate questions, and I think it's healthy to look at them.

The other one is, why don't we follow the UK's [United Kingdom] example on tuitions for health professionals? That has a trickle down effect to cost. I think we've focused on the extravagance of health care in the last fifty years. I think probably higher education is next in line. It's a good target.

DT: One of the other things that was debated—I don't know if it was ever started—in the mid to late 1970s was the Pharmacy Technician Program. Do you remember those discussions at all?

LA: There were discussions, but there was never any real commitment to move forward on that. It was decided that that wasn't within the mission of the College. That may be revisited at some time—I'm not so sure if within this College, but I think within pharmacy education generally. When I was on the council, we accredited 72 colleges. There are now 124, and the number continues to grow. Personally, I think we can't support that many schools. I think some of those new schools may become technician training schools. Much of Europe has technician education far in excess of what we do. I know the Nordic countries are up in the three-year range, and they have a much higher level of professional authority and responsibility than our technicians do. Personally, I

think that's the way to go. The question is how to train those people. Logically, a college of pharmacy should be involved in that. I'm not sure how it fits into this mission, unless there was a significant downsize in the enrollment, and I don't think that's going to happen.

DT: It looked like there was some discussion that the technician program would be better instituted at two-year colleges or technical schools.

LA: Vocational schools have had technician-training programs. We do have a national certification body for technicians. There's been a huge number certified. I believe that has value. But our Boards of Pharmacy still restrict the use of technicians. I think that's going to be the limiting factor, which will need to be addressed.

Actually, my Center just got through reviewing the entire Practice Act and determined that it's not a practice act that fits the current thinking in healthcare delivery. It was originally written in 1937. What pharmacists do has changed and what patients need has changed. So we made significant recommendations on making it acknowledge contemporary practice. One of the areas we addressed was technicians—that they be trained in a two- or three-year program and that those educated technicians have no ratio limits for technicians to pharmacists. I think that's a strategic goal. It probably won't happen in the next session of the Legislature, but we need to move forward on that.

DT: How does that relate to kind of concerns about workforce supply and fears about shortages of pharmacists?

LA: One of the people that spent their career trying to measure whether we have a shortage or a surplus is Jon Schommer in our department. A few years back we had a belief that there was a shortage here, a huge shortage. Pharmacists were getting signing bonuses in California of a brand new BMW automobile. It was a nice time to be starting the profession. In my opinion, there was never a shortage. There was a misallocation of manpower. Had we used the "shortage" as an opportunity to use more technology, robotics, centralized fill, those kinds of products, to enhance the role of technicians would have been a more responsible solution. I believe that's what the market was demanding, not that we produce more pharmacists. You produce more pharmacists and they're around for forty years. I think we misjudged that. We'd been better off to ask, "How do we make the system more efficient?" We didn't do that. But, now, because of the economies of health care, we're looking at efficiencies. At the same time, we've got this huge group of pharmacists out there who have expectations. We're going to double the number of graduates in this country. I think it's going to be 13,000, 14,000 next year or the year following, a huge number of people. You're already starting to see wages plateau, and some people are saying that they're decreasing with new hires. Two years ago, Walgreens cut the hours of all of their hires for that year's graduating class back to less than full time. So it was back to twenty-five, thirty hours a week, so they did not get benefits and so on. For a person just starting out, that's pretty tough. They should have been able to predict the needs better than that. I think the whole workforce issue is one

that is like Keynesian economics, you know. If you try to fine tune to much, you can overshoot your goal.

DT: You mentioned misallocation. I was wondering what the pharmacy supply has been like in rural areas.

LA: It's hard to tell because a lot of the rural pharmacies are closing due to mail order requirements, growth of chains, or they can't find a purchaser when they want to retire. So they just close it. It's a mission of this College to provide pharmacists for rural Minnesota. That was the reason for the Duluth Campus. I think we've been effective at doing that. But, there are going to be regions without pharmacists. Of course, there's experimentation in telepharmacy. If there's no pharmacist within a hundred miles of you can we do it with Skype or whatever? That's developmental, a good thing to look at.

DT: It looks like the College set up the Rural Pharmacist Associate Program in 1977 to encourage student pharmacists to go out into rural practice.

LA: Yes.

DT: Were you involved in or aware of those discussions?

LA: No, I was not involved in that.

DT: There was an RPAP program in the Medical School, the Rural Physician Associate Program. That came in a few years earlier. So I just wondered... It seems like, maybe, the pharmacists' had been modeled on that.

LA: I know that the program existed, and I think it was a valuable program. But it overlooked the fact that in inner city, metropolitan areas you have almost the same issue that you have with rural pharmacies in rural Minnesota. That was not considered. I thought that was a deficiency in the philosophy of that program. You can go down to the Selby Avenue/Dale Street area, and I don't think there's a pharmacy there. If that's your community, it's just as important that you have one, or a doctor, as some one who lives in in Blackduck.

DT: Yes.

DT: I'm blanking because I knew there was something else that came up that I wanted ask you about. Also related to the 1970s, but a little different, is, as I understand it, a Department of Social and Administrative Pharmacy was established. Can you talk at all about what the rationale was for Weaver to set up that department?

LA: The head of that department was Albert Wertheimer, who was the social side of the administrative, and he really felt that the social aspects of practice were important and unaddressed or under-addressed in the curriculum. So, he lobbied for that. He worked well with Dean Weaver and they got that through. It established a model for pharmacy

education in the United States. It's one of the feathers in this College's hat. I know Albert well. Albert is a very difficult guy to work with, but he was very effective.

One program in that was the Kellogg Program. Has anybody talked about that with you?

DT: No.

LA: In 1979 the Kellogg Foundation funded the Kellogg Pharmaceutical Clinical Scientist fellows for amount that was over \$1 million. There were fourteen Kellogg scholars. Those people have been phenomenal leaders in American pharmacy and health care. They were Ph.D. level. I hear stories of the way they were taught. One of them that has struck me—I think we need to some of this in the Pharm.D. program—is that every week, they'd get together and discuss the front pages of the papers and how those stories relate to health care and the profession. The program graduated a group of people who were very well informed about the world in which they were going to live and practice.

I think the program was unique, certainly unique to us, and I think unique to the Academic Health Center. Professional education tends to turn out people who are technically trained and not well educated. Albert addressed those issues. I think it was a really strong program.

The other side was that there was a diminishing allegiance to the value of business-related programs in a professional program. Why does a pharmacy clinician need to know business? Those of us who were in practice said, "What don't you understand? Health care is a business. Our people, in order to compete and deliver their services, need to know that." Those were the two pressures, the social one and business. Today, I think most practitioners would say that our graduates come out with insufficient business knowledge about how the health delivery system works.

DT: Can you talk about the development of pharmaceutical-care practice and what it meant?

LA: There's a continuum that started with the clinical pharmacy that I talked about, and the Pharm.D. was a branch of that. Pharm.D. is not a lineal descendant of clinical, I've been told, and I think that's correct.

Then, Linda Strand and Doug [Douglas] Hepler twenty-five years ago at a national retreat on the East Coast, enunciated the concept of comprehensive pharmaceutical care. It caught the profession's attention and stormed through it, worldwide. Linda Strand and Doug Hepler were given the Remington Medal by the profession of pharmacy, which is the highest honor that our profession gives to somebody for how they changed the way pharmacists think. It was well deserved. Their goal was to establish it as the core practice for all pharmacists. They developed software to support it. Bob Cipolle is part of that. I'm sure he talked about it. Everybody agreed with what it was trying to do and agreed that it was the right way of looking at drug therapy and its management. But they came up with a cumbersome program. The markets took that program and started to morph it

to meet the practice capabilities and so on. Linda was kind of turned off by that. She said, "How dare you? This is the King James Version. Don't you rewrite it." There was a tension there. But, then, other people looked at it and said, "What it's trying to do is very valid."

I was at a meeting a number of years ago when we were debating that the consumer doesn't understand what pharmaceutical care is. It sounds like something out of a drug manufacturer. Our profession changed our professional associations' names from pharmaceutical to pharmacy or pharmacist associations, because we didn't want to be allied with the industry. There was the same problem with pharmaceutical care. At this particular meeting, we had a fellow that got up and said, "We need a new name. How about Medication Therapy Management?" Everybody said, "Yes, I understand that. That's a great name."

Subsequently, it's been found that patients are turned off by the word therapy. "I'm not in therapy. I'm just taking a prescription." Some of us at Minnesota, myself included, are trying to retrain ourselves to say, "Medication Management." MTM is still on contracts, but we spell it out as Medication Management. Medication Management then is the operational aspect of pharmaceutical care. The concept is still called pharmaceutical care. We teach pharmaceutical care. When we talk about delivering services, we talk about med management. That is, I think, within the practice community seen as core practice. But the dilemma is that there's not enough people paying for it to make it a sustainable model of the practice. As a result, it's kind of like you're sitting there with a dance card that's empty, and nobody is coming over.

We've graduated 2500 pharmacists since 1996. They're all eligible by virtue of their degree to deliver comprehensive pharmaceutical care under a med management system. We have 150 in our U Plan network. Where are the other 2300? They're working in practices that can't sustain the practice, I think most of them. One of our hopes on Part D was that it would drive sustainability in the profession by providing opportunities to deliver the service. It didn't work.

We have programs. Minnesota's Medicaid program includes MTM. Who pays for MTM? DHS, Health Partners, UPlan pays for it in this market. I think Blue Cross uses the telephone service provided by Linda Strand, which is antithetical to her comprehensive pharmaceutical care beliefs. What we have now is that the abilities of the practitioner are out of sync with the markets, not the market's needs, but with the market recognition of the value of pharmacists in solving these problems.

I don't know how that's going to resolve itself. I'm right in the middle of it, and I find it really frustrating. The payer and the practice need to come together. We try to bring business to the pharmacies, and they're up to their eyeballs with the job of filling prescriptions. They have to fill 400 prescriptions a day to stay in business. They don't have time to spend an hour with somebody even at a good compensation rate." So there's that dynamic going on. How will it play out?

We've got another movement that's parallel but divergent with this. We're going to start to accredit pharmacy practices nationally. There's an organization called the Center for Pharmacy Practice Accreditation. It has standards out for comment now. It will drive the accreditation. In the Netherlands, they did something like this three, four years ago, and they got the insurance companies to increase the compensation to offset the cost of the accreditation. So it made it at least revenue neutral for the pharmacies. They're getting good uptake on that.

We need to have that same conversation with managed care in this country. Then, we're going to provide a higher level, a predictable level of service. And you need to pay for that, because it's going to cost the people money but will reduce costs. That's a discussion that is ongoing. If medication management in community practice is going to go, these insurance companies and public assistance programs are going have to recognize the value, put it into place in the benefit, and pay for it. That's one equation that needs to be addressed.

The other one is what's the role of pharmacists in med management in the ACO, health home, and all this new team concept of healthcare delivery where risk and reward are shared? Does a pharmacist clinician have a role in a group like that? We know that the pharmacists doing those things can bring savings and, therefore, bottom line to these organizations. How will they be integrated into those programs? It's a decision that hasn't been made, mainly because the organizers of ACOs are still focused on prescriptions and not on the clinical service that they provide. If you talk to physicians, they say, "If a pharmacist comes into this group and does all these things for me, it's going to free up my time. I'm going to be able to have more patient billable hours than I did before." So it's going to be net revenue to the group, and its also going to increase the quality. So physicians who work within those kinds of groups really like it. But it's a hard message to get across. Certainly, the Minnesota Hospital Association who is a big advocate for ACOs still sees the pharmacy inclusion as a product distribution issue, primarily. It hasn't really taken to med management.

Pharmacists are going to have to push their way into those organizations. They're not going to be invited in, because they're not in statute. That's contrary to the way pharmacists think. We are not that aggressive, professionally. At the practice level, we don't have those kinds of contacts. It's going to be a difficult time for pharmacy. I think the verdict is still out on how pharmacists will participate in that.

When Governor Arne Carlson was in office, I was asked to chair a committee for the Department of Health on designing a standard minimum benefit that all health plans in Minnesota would have to offer, and you could go above that to your heart's content. We worked on that for a long time. We had representatives from *all* of the health professions at the table. Each one of them was asked to describe *the* essential element of what your profession brings to the overall goal in health care? We really worked hard on that. I think everyone really got right down to the core value of its profession. What has to be in the benefit? We put it out, and it was killed by the Buyer's Health Care Action Group, which represented the purchaser. They said, "Well, we don't want to buy all those core

values of all those people.” Actually, they threatened to walk out. I had to really twist an arm to keep them at the table. As a result because the business community fought it, it never went anywhere. Fifteen years later, we’re still trying to figure out what our core benefit is. I think it’s essential if you’re going to do any reformation.

DT: Obviously, the core value that cuts across all the healthcare providers, but at least in terms of pharmacy, this seems to reflect the central tension that pharmacists have dealt with, at least in the last few years, in what is the changing identity of the pharmacists and the changing nature of pharmacy practice?

LA: Yes.

DT: I remember now when Bob Cipolle was talking to me about pharmaceutical care and MTM, and, in talking about it, yes, isn’t that like a defining feature of what a pharmacist does? But it hasn’t been valued in that way. Since Apple’s pushing for a more professional view of pharmacy, it seems in order to be taken seriously by the healthcare consumer and other members of the health team and to be reimbursed by insurance and government agencies, it has to be codified.

LA: Yes.

DT: It’s a shame, because it sounds like from the pharmacists I’ve now spoken to and my research, that’s always what pharmacists have sought to do is to be comprehensive in the kind of care...

LA: Yes. There are some issues in this. One is that there’s no agreed upon definition of MTM. We have MTM programs that go all the way from a Part D definition, which is pretty minimal, a phone call, to what I think the U Plan’s is, which is quite comprehensive, and there’s everything in between. So when an employer, a purchaser, is asked, “Would you like to put MTM into your benefit?” What does that employer think? That’s really difficult. My strategic concern is that the purchaser will define it as the minimal. I think the needs of the community are vastly different than a minimal level.

The other part of it is that we don’t have a brand in this business. If you asked a person on the street, “What does a pharmacist do?” it would depend on which pharmacy they went to last. If it was one where they got the prescription bag thrown across the counter followed by: “Do you have any questions?” Or something like that, that’s one definition, or if you go to somebody that’s a full service pharmacy, that’s another definition, and it’s all over the place. Our brand is individual, consumer-by-consumer and pharmacist-by-pharmacist. That’s not sustainable in a market.

Then, of course, even more fundamental than that, we don’t have a professional brand. We don’t have a pharmacy brand, and we don’t have an individual pharmacist brand. One of my complaints about practicing in a big box is, how do you distinguish yourself professionally when you’re in a backroom looking at people through a peephole and they never know your name, because your nametag is twelve font? That’s it. Having

practiced with a personal and professional brand, I believe it would be difficult to not have that.

DT: That's really interesting and quite striking.

LA: An issue of this college is how do you instill in young pharmacists that branding is essential, both for you and for your profession, and you're going to decide that in your professional lifetime. That need needs to be taught. I advise students to begin to work on establishing a personal brand immediately. It's not intuitive.

DT: Using physicians as an example, they've never really struggled with their brand.

LA: No.

DT: Everyone knows what a physician does, even though in reality what a physician does depends on the specialty, depends on where they practice. But maybe general practitioners have had difficulty branding themselves and rebranded as family practitioners, family physicians. That's where pharmacy and arguably nurses to a lesser extent... Everyone knows what a nurse does, except as nurses started to have greater professional aspirations and demanded better recognition for what they did, they had to struggle with the brand. So it seems this inherent hierarchy within the healthcare profession...

LA: Yes, I think within nursing now, they've confused their brand by having all of the different levels. I hope pharmacy doesn't go that way. I think that all professions tend to attempt this.

DT: Your comments earlier about Medicare Part D make even more sense as we've continued the discussion. If Medicare Part D had charged individual pharmacists with the responsibility for MTM, that would have given economic and administrative legitimacy to MTM. But because it's going through the PBM, that kind of undermines that goal.

LA: Yes.

DT: That just reinforces what you said earlier, how important Medicare Part D could have been.

LA: Yes. That's the way it was looked at when it was put into the law. That was the hope. It, obviously, didn't pan out.

The other part, of course, is it has substantially defined a brand for MTM that, in my mind, is incorrect and misses the mark for the service entirely. Those are big issues.

DT: The example you gave where the Buyer's Health Care Action Group walked out of the discussions, it's the purchasers that have so much power.

LA: Yes. I think the current leadership over there is pretty understanding of the value that MTM brings to their membership. Carolyn Pare has been very supportive and has worked with Brian [J.] Isetts on our faculty on the MTM value proposition. He's on loan to CMS now, CMS Innovation Department, which I always thought was an oxymoron.

DT: Can you talk about the Center for Leading Healthcare Change, and what it is?

LA: Sure. Over several years Dean Marilyn Speedie and I had had discussions about the shortage of leadership in health care, and pharmacy specifically, and the role of the College in changing that. We were really on the same page as to our assessment of the need and, also, the ability of the College to influence it.

When I left practice, she invited me to come in and do what was, essentially, a market analysis of how the College could address that issue. That was the sixty-five interviews that I talked about earlier. We wrote that up and brought it back to the faculty. It was really an assessment of how well the College had prepared these sixty-five graduates for what they ultimately did in their careers—not what they thought they were going to do when they were in school. The sixty-five were all the way from new graduates to retirees. We brought the results back to the faculty. There were a number of things that they said the College did well, and there were a number of things that they thought that the College could have done differently. So we looked at that and said, “Okay, can we start a leadership center that will address those deficits?”

That's the Center for Leading Healthcare Change. It has four foci. One is practice advancement, and you do that through advocacy as well as preparing students to do it. Executive leadership recognizes that people, in all professions, change their career goals. We believe that can have a role in preparing them for not only a mid-course correction but, also, to train them within the curriculum to be innovative, adaptable, and risk-takers. Another area was policy. Pharmacists traditionally are not at the policy table. Historically we have been in the position of responding to other people's policy development and ideas. Pharmacists needed to be at the table, and as a profession, we needed to work to have pharmacists generally interested in and willing to affect policy where they could. The other one was preparing students in the Pharm.D. curriculum through leadership courses. That was the easiest part, because we have a couple of faculty members who have just done a phenomenal job of developing leadership courses and have been doing it for several years. The reputation that they had and the understanding of their importance made it much easier now to make leadership a major focus of the College.

So we started the Center and working with the entire faculty and the students as a nexus for leadership rather than really a producer of all the leadership courses. We are where it comes together. Our title is rather grand, but the philosophy is that the true change in health care has to begin at the level where practitioners and patients meet. You can enforce policy downward, but effective change is really going to originate where care is delivered. So we have to educate our people to be able to lead in their communities and

in their practice to improve the qualities in all aspects of healthcare delivery. To accomplish this takes leadership., I think in the health sciences we don't necessarily attract leaders, at least not consciously. When I first came onboard, I visited the other five schools and I talked about, "What are your leadership activities?" It was interesting. It was all the way from, "We don't do anything," to "Well, all of our students are, by definition, leaders." Again, I think it's a fault of the Academic Health Center that there was no inter-professional understanding of the value of leadership and AHC's role in promoting leadership within its students and within its faculties. I think that's still not there—at least it's not obvious that it's there. There are things that can be done in the AHC. As an example, the AHC should have a congressional rotation for one of its students in Washington [D.C.] with each member of our congressional delegation every quarter. We'll get an angel to buy an apartment in Washington, and these people can stay there and so on. If we want people to be leaders, put them in leadership positions.

DT: Yes [whispered].

LA: I think those are simple things to accomplish yet I don't see movement. We have meetings after meetings after meetings, and the committee chairman becomes a leader and nobody else.

So we're addressing it in the Center. Nursing also has a program, and I think it's a good program. It's a little bit different than ours. We're both having good effects. We're leading advancements in practice through our MTM benefit and expansion to other managed-care organizations. We're contracting now with others, and we'll spin off that network, hopefully, similar to what UCare was spun off from family practice, to be a freestanding corporation comprised of pharmacists. That will drive changes in the profession. I think that's good. We continue to increase the numbers of leadership courses within the curriculum. The numbers of students taking those courses increases. We facilitate opportunities for students to apply leadership skills. My Center is partially funding two students to present at the International Pharmacy Federation in October, and we have for the last three years. We're the only College of Pharmacy in the United States who even encourages its students to participate in those programs.

On the policy side, we've got some people here who are well positioned in the policy development. It needs to be expanded. Things like rewriting the Practice Act. It's a practice advancement type of program. Let's get the barriers out of the way so that our students can practice at the limits of their education, not the limits of the law.

Marilyn Speedie and I co-direct it. We have a Board of Advisors of about a dozen, mostly internal but not all. We've put on programs... We had a series of four annual conferences on managed care leadership. Our goal was to return pharmacists to the C-level in managed care. In the early days of managed care, pharmacists were in the C-level of many of these new companies, and they were very innovative. As of late, there's a glass ceiling for pharmacists. How do we overcome that? We put together these programs that brought together senior management and pharmacists to show senior management that pharmacists could contribute and that pharmacists would see, "Hey,

being a senior manager is kind of cool.” We brought those two together on the same program. It was *so* effective that the Academy of Managed Care Pharmacy wanted it for their own. Since they were our partners, that’s fine, because that’s leadership that’s handed off to somebody that will continue it, and I’m really pleased with that. That’s the kind of stuff we do. It’s kind of fun.

Years ago when [John F.] Kennedy was president, Dean Rusk was secretary of state. He commented as he left the cabinet that everyone should, when they leave their active profession, go into education. He went to the University of Georgia, and he taught for a number of years. That always stuck with me as a good career ladder. So I followed that, and I think he was right on. It’s a lot of fun to work with students.

DT: It sounds like the College has always maintained good, productive, constructive relationships with pharmacists in practice.

LA: Yes.

DT: In the Medical School, there are decades of old tensions between town and gown, not just here but anywhere.

LA: Sure.

DT: It doesn’t sound like that’s been ever the case with pharmacy.

LA: No, and it’s even broader than that. In this state, going back as long as I can remember, the College, the Association, and the Board have worked very well together, not always of like mind, but that’s okay. The personalities at the top in all of those three groups saw the value in that. I think that still exists. That collaboration got Weaver-Densford Hall built, Unit F The MTM into the DHS Medicaid program was because of that collaboration. So there’s a whole lot of instances where that has been very effective. It’s not unique in colleges, but it’s pretty rare, especially when you get into states where they have multiple colleges. You have too many centers of force, and it’s just too difficult to do. Here, we’re very fortunate; we only have one college.

DT: It’s a little distinctive for Minnesota then?

LA: Yes, I think so. I think Minnesota has a culture where the state, as with Iowa... Actually the region, Iowa, the Dakotas, Wisconsin, we’ve been dominated by independent practice rather than chain practice. Even though that’s changed, the culture of that community involvement, personal responsibility has continued. I think that’s reflected here as well. It made it easier and, plus, we’re, for the most part, all the same gene pool. It’s northern European, historically. Although that is changing now—and this change is having positive effects.

DT: Do you think within pharmacy and maybe in Minnesota or more broadly, there are tensions, say, or just more professional disagreement between the different kinds of

pharmacists, the community pharmacist versus the hospital pharmacist versus the pharmacists working in the chain stores?

LA: I don't know if it's tension as much as it's fragmentation that could be perceived as tension. Our state associations were—this is nationally now, not just Minnesota—very strong when the practice was dominated by independents. They all joined, and they were active, and they had common cause. With the growth of chains, the balance shifted. A lot of the services that were provided by state associations—continuing education, legislative representation—are being done by corporate employers now. So pharmacists don't need to join an association to get these benefits. They say, "Corporate takes care of that, so why do I need to belong? I work my forty hours, and I'm tired, and I want to go golfing." That's part of an American culture, work-life balance. So the state associations have diminished in viability and diminished in importance. At the same time, the number of pharmacists who practice in hospitals has increased—a huge number now go there compared to practice in the community—so hospital associations have become stronger.

Some states have melded the two together to their advantage, but the ASHP [American Society of Health System Pharmacists] has, historically, fought that. The executive [Henri R. Manasse, Junior] who led that fight has recently retired and the new executive of the ASHP [Paul W. Abramowitz] actually was the chief pharmacist at the University [of Minnesota] Hospital for a while and, then after that went to Iowa, so we think he may have a different culture than Henri had. So that may change. It's yet to be seen. I think strategically those two groups have to come together, because neither one of them have enough people to support them in the way that they should. So there's that organizational change that goes on.

There's a very real tension between the practice, wherever it is, and managed care pharmacists. I think part of that is because managed care pharmacists have distanced themselves from the practice associations. So it's hard to talk to one of them. When a pharmacist calls some of our managed care organizations, they can't even talk to a colleague, which makes it even more stressful. Plus, the managed-care pharmacists, differ from physicians in managed care; they have not represented their profession as well as physicians have. When I sat on the board at PHP and we were talking issues, the physicians would say, "Well, I think if we do that, it's going to affect the physician's ability to take care of the needs of our members." When we would do a similar type of discussion about pharmacists, the pharmacy director would say, "Yes, I think they'll go along with that because they need the money." So there was lack of positioning the profession as an integral part of the goal of the managed-care organization. I think that hurt us a bit. So there's a tension there.

Yes, I think there are tensions, but there are also some common issues that need to be addressed that we really could come together on. We've got new leadership in our national associations, both the APhA and the ASHP and, also, AMCP, the managed care people. I've been with all three of those at the same time, and they have a much different and more collegial relationship than their predecessors did. Hope springs eternal.

LA: In that case, stuff does start at the top.

DT: It sounds like that's also something that the Center for Leading Healthcare Change is set up to do, to prepare students not just to assume leadership positions, but to have a productive attitude towards the issues that confront leaders.

LA: I think that's true. One of the things that at least I keep harping on is that the College has to support its values. If we value activity in professional societies as a way to improve the world, then we ought to, when we go to experiential education, say, "Let's require that our preceptors be at least members and, hopefully, active in professional societies." It doesn't matter which one. If we value collaborative practice, why don't I and my network say, "You have to have a collaborative practice agreement"? What's our value? Of course, the question comes up, "How can we do that?" Is it important? Well, yes, it's important. Then, what's the problem? Everybody's bucket is full. Why cause problems that you can circumvent? That's just life. That's not academia.

DT: We've covered an awful lot of ground today. I wonder if there is anything else that you want to share about what you think have been the major changes in pharmacy practice and changes within the College.

LA: One of the things that I mentioned early on was the reliability of our drug supply. It's kind of a broad issue. It goes all the way from the environmental effect of drugs that go through the toilet, not as unused drugs but as metabolites of the drugs we ingest every day, and the effect that that's having on the environment. That is really a pharmacist's issue. My overarching concept of pharmacy is that anything that has to do with medicines is our bailiwick. So the fact that we're now seeing Prozac levels in wild animals, and we're seeing fish who have been feminized because of all the estrogen going into the sewer from birth control pills, that's an issue that is reasonably a pharmacist issue.

I think that electronic prescribing and the errors that occur in prescriptions is a pharmacist issue. I think the over prescribing of opiates that is such a big thing right now is partially a pharmacist issue, but the misuse of drugs due to over supply is, basically, a physician issue. They don't need to prescribe sixty pain pills when a patient has a hangnail. Give you three and, then, come back for a refill. Can pharmacy impact that? Yes, it can. When I get a prescription into my pharmacy, and it's got sixty Vicodin prescription for somebody that I know has a high pain threshold, I need to say, "Hey, George, let's just partial fill this. You don't need these sitting in your medicine cabinet." Pharmacists have to take that proactively.

When I have a new product that comes into my pharmacy, and I don't know what its provenance is, and I can't find it out, that's my issue as a responsible pharmacist. The amount of counterfeit drugs and the sub-standard drugs that come into our system is a huge problem. It's a pharmacist issue, and we're not addressing it. I just think there are

so many areas like this. The fact that nobody is in control of prescription medications in this country... We can get any drug you want through the Internet, without ever seeing a physician. Then, we get samples from your physician, and we go to primary care and two specialists and a dentist. We get all these prescriptions at the same time—some of them we're required by our health plan to get by mail order, and some of them we get from our doctors, and some of them we get from the Internet. That's a pharmacist issue, because we're the nexus for medications in our system, but in most cases we're cut out from managing this because of lack of an integrated information system.

This is driving part of the healthcare cost, but, more importantly, it's causing part of the undesirable outcomes of health care in our country. I think that part of the problem is that pharmacists are not recognized as being a resource and responsible for addressing these issues, but, more importantly, the pharmacy profession has not stepped up and told the world that *is* our responsibility.

I remember one time about seven or eight years ago, I was at our House of Delegates for the APhA, and I proposed a resolution that after a certain date, pharmacists would no longer accept handwritten prescriptions because they are the source of so many medication errors. California lobbied to defeat my resolution, because that would offend physicians. Of course, the argument is, when you can't read them and errors are made, are we really concerned about offending physicians? Pharmacists need to be more proactive in that. Part of the leadership thing is that you need to lead in those areas where you're expert.

Sorry, I'm on a soapbox now; you can tell.

DT: I'm going right along with you.

LA: I think similar things for other health providers. I don't see the health providers, the practitioners, who are individually responsible for health care in this country standing up and addressing the issues. Hillary [Clinton] tried to rewrite the healthcare laws without provider input, and I think Congress just tried to do it without healthcare providers [Affordable Care Act]. I think that health practitioners do have a point of view, and it's a valid point of view, because we're ultimately responsible. I can be sued; Congress can't. That brings us back to the Academic Health Center. Earlier, I talked about having congressional internships for our students in Washington and in Saint Paul. Get our students and young practitioners to be disciples of an enhanced quality of care and their role in providing that. Sitting around like Ant Lions, waiting for it to fall into our laps is not a business plan. I think that's missed opportunity.

DT: I agree.

LA: Enough said.

DT: It's been great. Thank you.

LA: Yes. Thank you. It was enjoyable.

I was going to buy your book [*Pills, Power, and Policy: The Struggle for Drug Reform in Cold War America and Its Consequences*], but \$65...

DT: No. You can get a paperback for \$20 or \$25.

LA: I actually found it in the library...

DT: Oh, good.

LA: ...and you can get it online for free.

DT: Excellent, even better.

LA: What's the response to that book?

DT: So far, it's been positive. I've only gotten two reviews of it, so far, but they've been positive. My colleagues in the History of Medicine have liked it. I was actually encouraged listening to you talk about the 1960s and 1970s and pharmacy and the kind of changes in pharmacy practice. Yes, that's what I said! Physicians who I've presented the material to who were practicing in the 1960s and 1970s have responded favorably to it and thought it represented...

LA: Do you ever give seminars on that?

DT: Yes.

LA: If we were to find a venue, you could do...?

DT: Oh, absolutely, yes. I'd be delighted to.

LA: One of our graduates Michael G. Wokasch wrote *Pharmaplasia*. I've got the book up here somewhere.

DT: Oh. No.

LA: He worked for Glaxo for a while, and he wrote this. It's kind of similar, but different. I think you might enjoy that. He lives over in Wisconsin now. He's retired from the pharmaceutical industry, but he finds fault with it.

DT: Oh, great. I'm surprised I haven't come across it. I've read, obviously, so much of what's been written on pharmacy. I'll have to get this.

LA: He's the one that really opened my eyes to the value of branding. He was very junior at Glaxo when they asked him to the product launch for this product. They didn't

really think it was going to go anywhere, so they gave it to this junior guy. He launched it, and it became a blockbuster.

DT: Yes.

LA: He said, “Early in my career, I established my brand as that and certainly will for my entire career.” That’s a cool idea.

DT: Yes. I’ll definitely have to take a look at that.

Thank you so much.

[End of the interview]

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