Interview with S. Charles Schulz, M.D.

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Interviewed for the Minnesota Psychiatric Society

Interviewed by David Cline, M.D.

S. Charles Schulz, M.D.: -CS
David Cline, M.D.: -DC

DC: Good morning. I’m Dr. David W. Cline, psychiatrist here in Minneapolis-St. Paul, and we are at the Hastings Library in the Department of Psychiatry at the University of Minnesota Medical School. We are continuing our project of getting oral histories from senior members of the psychiatry community here in the State of Minnesota, which has been supported by the Minnesota Psychiatric Society and also Minnesota Historical Society.

This morning we have Dr. Charles Schulz, who is chair of the Department of Psychiatry, and who occupies the Donald W. Hastings Chair in Psychiatry. Dr. Schulz is going to tell us about his career and also about his work as chair of the Department of Psychiatry during these last eleven years here at the University of Minnesota. Welcome, Dr. Schulz.

CS: Thank you very much. It’s a treat and an honor to be included in this project.

DC: You’re welcome. Would you start by telling us where you grew up, where you were born and some of your background history of your family and things of that nature?

CS: I’d be happy to. I was born in Evanston Hospital. I’m the oldest of three boys in the family. It turned out that [my] family lived in a Chicago suburb, Deerfield, till I was about nine. My dad got transferred to Green Bay, Wisconsin, for a year.

DC: What was his work?

CS: He was working with NBC Television, and was the station manager for the NBC station in Green Bay. And then he got transferred back down to Chicago, and rather than go back to Deerfield, we moved to Evanston, Illinois, where I went from fifth grade till the end of high school at Evanston Township High School.

DC: And your name is “S.,” which I believe is for Sellmann? I am wondering where that came from, from your family?

CS: Well, I think you also know I was a history major in college, so I always love the background stories. Turns out that my grandfather was Sellmann Charles Schulz, and he was
born in 1898, and given the name Sellmann to remember the family that had emigrated from the Koblenz and Berne area of Europe. They felt that by using the last name of his aunt they would be able to keep a family tradition going.

DC: Remarkable! And did they immigrated to the Chicago area, as many German descendents came?

CS: You know, it turned out that the family moved to the Evansville, Indiana area in the mid-19th Century, in the 1850s. And my grandfather’s father, interestingly enough, was a pharmacist in Evansville. My grandfather was born in 1898, went to Evansville High School. You may have been down into my office. I know I’ve shown you a picture of his winning the state championship in the 100-yard dash in the State of Indiana, back in 1916. In his career he went forward – similar [to] my dad working with NBC, my grandfather became the vice president of Decca Records, and had become involved in the recording industry during the 1930s, where, I think you’re aware, there was a pretty big increase in recording and selling records and stuff like that.

DC: Popular records, the jazz age, and swing, those records? Or was it classical music as well?

CS: The whole thing. I can remember as a young boy in junior high, Decca Records developed a relationship with Deutsche Grammophon, and so I would get stacks of Deutsche Grammophon LPs to play, and he’d say – What do you think of this one? From Tchaikovsky to Kodaly to Rachmaninoff. It was delightful …

DC: Those were classic pieces.

CS: They sure were.

DC: So did that lead to your own interest in classical music?

CS: I think that background, along with all the piano lessons I took from first grade through up till junior high school led me to really enjoy classical music a lot.

DC: Do you play, still, some?

CS: No, a lot of other things came up in those intervening years and I haven’t been able to stay with playing the piano.

DC: But the appreciation of music that came with those lessons and … still part of your …

CS: I think the lessons and all of the wonderful recordings that he gave me were really part of my enjoyment with music. And now, my son, who is 25, William, lives in Los Angeles, plays with a rock and roll band and is a production assistant in recording TV shows and other things like that, so he’s stayed with this interesting arena of music and entertainment and recording. He plays the guitar.
DC: That goes way back to your grandfather.

CS: I think so.

DC: My, that’s an interesting legacy.

CS: I don’t know if there’s a genetic link or not, because I’m not very artistic. But sometimes these things skip a generation or so.

DC: You’re a carrier. [chuckles]

CS: That’s it.

DC: You carried it on to him.

CS: Yeah.

DC: Well, what else happened in your formative years that is of note to you-- in school age and high school age?

CS: You know, I appreciate that I’ve had a chance to talk a little bit about these interviews, so I’ve been giving this some thought. I’ll talk a little bit about, maybe, medicine first.

During my even elementary school and certainly also through junior high, but I think especially in junior high, as people began, they had to plan for high school - What are you going to take, what are you going to do? - I really enjoyed the natural sciences and so counselors pointed things out, like maybe medicine or being a doctor would be a good thing. I think I was fortunate to grow up in an era and maybe also a part of the country, the North Shore off Chicago, that there was also an idea that you would pick a career that would be helpful to others. Maybe even, at that time, remembering Kennedy’s speech when I was a freshman in high school – “Ask not what the country will do for you, but what you can do for your country.” There was a real spirit.

DC: You felt that and it took ...

CS: And I think a lot of my classmates did, too. So it was really in my junior high school era that I thought about medicine. Our family pediatrician was a wonderful mentor. I used to be able to go by his office and shadow him as early as eighth grade and he was a close family friend and I really admired him. I think when a person has an experience of observing a person in a field that they really think is a wonderful man, that it assists a lot in where you want to go with your life. So I, as early as eighth grade, almost, planned out all my high school courses to make sure I got the chemistry, physics, math – everything I would need in order to be a competitive pre-med student in college.

DC: Did that include Latin, then?
CS: I took Latin in junior high, took German in high school. Interestingly – now what is this – 50 years ago – a substantial amount of medical literature was written in German, and so one of my advisors said – It would be a good idea for you to take German because you never know when you might have to read a book. I don’t think we have that so much today, but 50 years ago that was something that was recommended.

DC: Sixty. Many formative works came out of German science before the war. So then you were pretty much set in a career already, early in grade school.

CS: Yes I was.

DC: Any deviation from that ever come along, like – I should have been a history professor – for example?

CS: There was one other thing that happened during high school that also had a pretty formative impact on my life, and that was, as I started high school some friends of mine suggested it probably would be a good idea if I went out for the cross country team, because I’m a little short, or very short, depending on your perspective, and they said, the football team’s not going to work for you, but why don’t you go out for cross country in the fall and then if you want to play baseball or tennis in the spring you’ll be in really good shape. So, I went out for the cross-country team and was really fortunate at what a connection that was. I had, I guess, some natural endurance, and by the end of the cross-country season made the varsity team and we went to the state meet. That was very enthusing for me. Just a lot of fun and kind of rewarding for self-esteem and stuff like that, to be a freshman and be running with the juniors and seniors and that kind of stuff.

DC: At a state tournament, no less.

CS: I was fifth man, not first, but still made the team and we went to the state meet and that was pretty exciting stuff. I may not have mentioned to you, but it turned out that I ended up being the individual state champion of cross-country in my junior and senior year.

DC: My! I didn’t know that.

CS: This does have an impact on my career, because I, through track and field and having not such bad grades in my courses in high school, I was able to get a full scholarship to the University of Southern California. So I was able to run cross-country and track at USC and also to be able to do all my pre-med training there.

DC: Was it a good school for you? Did it fit? Did you love that college experience?

CS: I would have to say that, other than the pressure anybody’s under in pre-med – you know, you gotta get good grades and all of that kind of stuff, study really, really hard – that University of Southern California was a really terrific fit for me. We had just outstanding organic chemistry, embryology, all of those classes were really great. Of course, I was just thinking I’d be a doctor. It hadn’t occurred to me yet that psychiatry would be where I was going. You know, my family
doctor had been a mentor and I hadn't really learned much about psychiatry, even through college. I would say the opportunity to be in Southern Cal, which, during the time I was there, our track team was the NCAA champions, three out of the four years, was pretty neat. I got to be a part of a really outstanding crew of people who set world records and went to the Mexico Olympics — just amazing stuff. I wasn't at that level, but I was a member of that team and actually elected captain my senior year. That was quite a treat.

DC: I recall that you had some connection with O.J. Simpson some place along in there.

CS: It turns out that when I was a junior, O.J. transferred to the University of Southern California from San Francisco City College, and he was an outstanding runner and joined the track team. So O.J. and I and other really famous track guys, people who did track and football were — we were just all out on the field together every afternoon. He was quite a nice guy. Humble, fun, did everything with us, wasn't like — Oh, I'm O.J., etc. And he had not played for Southern Cal yet that spring. I saw O.J. a number of times ten years after graduation, still really a neat person and ... you know, it's a difficult thing to know somebody and to have been friendly with him and have everybody on the team think he was a great guy, and see him take a direction that was so bad. It was a very interesting experience. [O.J. Simpson — All-American football player in college, professional football Hall of Fame; later accused of murdering his ex-wife and her boyfriend, but acquitted in “show trial”.

But there were other folks on our team that were really in that same category, gold medal winners in the Mexico Olympic Games — Bob Seagren in the pole vault, for example, and world record holders in the 440 relay and the two-mile relay. It was quite a crew.

DC: My — you were in good company!

CS: I was in good company. It was a pleasure.

DC: Anything more about college, or medical school.

CS: I think you asked was it a good fit, and I would say it was a really good fit. I had the opportunity to take some wonderful classes. I'll just maybe add one more thing.

I'll never forget going in to see my counselor to plan for my second semester of my freshman year, and he said, OK, you're going along, you're a biology major. Pre-med's not a major, as you know, in most colleges. So he said, well, you're a biology major and we have to sign you up for botany and you'll have labs on Tuesday and Thursday afternoons and stuff like that, and I'm going — Oh, OK, and I'm trying to think how that's going to work with cross country and track practice, so I went and talked to the coach, and he got a little upset, and he said I could not take labs in the afternoon. So I went back to the counselor — what a great guy. He said — You know, you don't have to be a biology major. Let's take a look at what you need to go to med school, and we plotted out a four-year plan for me to do everything I needed to go to med school, and I was fortunate in that I had passed out through a number of science and math courses by taking AP [Advanced Placement] class as a high school student. So I had a lot of flexibility in my schedule, and he said — “What do you want to do?” And I had a great ancient history professor,
so my college career was ancient history, medieval history, classics, classical art history, and it was – I mean, how well-rounded and fun, to learn all that great stuff! Still love it, still love it, still read about it. Never forget, I gave a lecture with Apostolos [Georgopoulos—a colleague] in Athens, and walking up the hill at dawn to the Acropolis, walking around the Parthenon and knowing, you know, where the Parthenon is and the theater where Sophocles and Euripides plays [were produced] is right off to the right there from the entrance, and I'm looking down there just totally amazed that I had read all their plays and here I was standing where they had been performed.

DC: Quite something, isn’t it?

CS: It is.

DC: A moving moment. It’s striking that this incident of labs in the afternoon sort of switched your orientation to something that was really meant to be, I mean something that you really savored. That is, it was just a turn of fortune for you to have that happen.

CS: It had another interesting outcome. Turned out that UCLA, across town, in the era of the late 60s had decided that what they wanted were physicians who were more balanced than the ones they had been accepting, who were physics and chemistry majors, and so half of the class had liberal arts degrees, and I'm pretty sure I got selected – One of my anatomy lab partners was an art history major from the University of Wisconsin. I mean, we had to do all of our courses and everything, but I think that having had that background was part of what – I did my science but I also did my ancient history major and stuff like that, so I think I was, at that time, their idea of who's a well-rounded guy.

DC: Yes, I remember that era as getting away from the solitary scientist who just wants the facts to somebody being personable and engaged and know the world. Be educated, in the full sense. And that was you, then, that was you, and you applied to UCLA for your ...

CS: I was really, really lucky. No doubt about it.

DC: So that was medical school. And at that time, Jolly [Jolyon] West, I believe, was the chair of neuroscience?

CS: Well, it turns out that when I started med school, Norman Brill, the founding chair of the Department of Psychiatry was still chair. Norm was a ... I don’t know if he was the head of the Washington-Baltimore Psychoanalytic before coming to UCLA, but he was certainly a strong member of that organization and the department was a highly visible psychoanalytic department with some application to consult-liaison service, and in that period of time of the 60s, the examination of the psychiatric aspects of a number of physical illnesses – ulcers, arthritis, and etc., asthma, had a very detailed psychoanalytic etiology theories. So UCLA was very prominent in psychoanalysis and in psychoanalytically-oriented consult-liaison service. The interesting part for me and related to the idea of how did I get involved in psychiatry, was they had rounds with psychiatrists for medical students the first week of school. We started off – and I know you do this – make these things available for our students too – which has been really great – but what I
experienced was the first Friday of med school, Fred Gottlieb, a psychiatrist at UCLA, took six of us around and we visited a woman with hepatitis in a hospital bed and he was talking with her about her emotional and social issues, and it turned out she was having a number of emotional things going on in addition to her liver disease, and we watched him interview her and talked about the case and formulated it. We had such a wonderful psychosomatic CL service — and as our faculty here, unfortunately, has had to hear me say so many times — for me it’s a consultation and a liaison service, not a consult service, and that’s what I learned from Fred Gottlieb. Dr. Bob Pasnau was our head of consult-liaison. You know he became president of APA [American Psychiatric Association]. And so, we had connection with these outstanding faculty [members] right in the first week of school. I really liked that, thought that was really neat.

DC: So then psychiatry caught your eye early on …

CS: But it took a couple years, and it turned out that after my first year I was given a fellowship at Cedars-Sinai Hospital. I liked internal medicine, physiology in the beginning. I was trying to learn how to be a doctor, and I got assigned to Cedars-Sinai to work with Jeremy Swan. Jeremy Swan’s the inventor of the Swan-Ganz catheter, and I was pretty lucky to be there the summer the studies were finalized and the New England Journal article came out in the fall. So we were looking at hemodynamics, I was learning a lot about it. He ran such an amazing research group. I mean, you just couldn’t help but think this was a wonderful guy. And then it began to lead me to think that there’s more to medicine than becoming a family doctor or a family pediatrician, that maybe I could get involved in this cardiology research and make more of a difference.

So, then I was selected to do a pathology fellowship, in between my second and third year of med school — “pull-out” year. NIH [National Institute of Health] funded five people. I was doing autopsies and learning about the body and studying and I was really excited. I was really moving ahead. Two things happened that year. One, they moved outpatient psychiatry from third year to second, and they called me up on the phone and said — Chuck, you’ve got to go do your outpatient psychiatry rotation, it’s in the evenings, because when you’re third year, it won’t be there, and you won’t get to graduate. So my friends and I that were path fellows had to go take psychiatry outpatient clinic. I can remember the contrast of standing in an autopsy [room] by myself, versus being with a team of psychiatrists and nurses in the outpatient clinic and the people we saw — I was so lucky — got better over their six weeks of kind of crisis-intervention and stuff like that. I began to think, boy this is … I like this job.

That same year, a friend of mine was a social work student, and she, during my spring vacation, she said — I have to go up to Camarillo State Hospital for a field trip thing and write up a little report. Want to go with me? ‘Cause she had heard me talk about psychiatry. So we drove up to Camarillo. It’s about 90 miles north of LA. Camarillo — classic old state hospital. This is 1970-71. Two thousand patients. Oh my God! Seeing these people, which I’d not before. My first two years of med school were kind of on the UCLA campus or at the VA or something like that. But seeing the severity of these schizophrenic people — some were catatonic, some were just wandering around the campus. Others were in occupational therapy, and they were putting little flower plants on top of pens. Kind of moving it through like that is essentially basket weaving therapy stuff. I just thought, who in the world is going to take care of these people? It just dawned on me. I knew other of my friends wanted to be ophthalmologists and orthopedists and
other things like that, and I just began to crystallize then that maybe if I went into this area, I might be able to make a bigger impact on medicine than if I went into cardiology. So that pull-out year of pathology, interestingly enough, the contrast to psychiatry. So then, I went back, talked to my mentors, Fred Gottlieb, Bob Pasnau – Jolly West had then become chair – and began to explore what would I need to do to get into the psychiatry program at UCLA. I can remember those appointments. Sitting with Bob and his sanguine – “You know, you may want to do this, these are the electives. You might want to do those a fourth year.” Everybody said make sure you do an acting internship in internal medicine and pediatrics and everything like that, because you’ve got to be a good doctor.

DC: Yes, learn how to doctor.

CS: So I took that advice, and I was really lucky to get into the UCLA residency program.

DC: Lucky, you think?

CS: Oh yeah.

DC: So, it was competitive and you, in spite of your quite significant background, it was still competitive. That’s interesting.

CS: Oh, sure.

DC: Your experience at Camarillo, that’s quite interesting. It might be what we would say was a calling that you felt that day. You might have had revulsion to all this – Who wants to take care of these – not me – kind of. It could be an understandable response, but quite on the other hand, you were drawn to it, or had some ...

CS: It planted a seed. I would have to say, looking back at … that it planted a seed. It was not as if in my junior and senior year I spent all my time trying to figure out how to help people with schizophrenia. Most of the focus of UCLA was C and L. So I took C and L electives and etc., etc., rather than saying please get me back up to Camarillo. But it will cycle back to schizophrenia in just a little bit.

DC: I’m remembering now that Jolly West did come in ’69 or ’70 to UCLA, and I know that because when I was here at Minnesota, early in ’68, Dr. Hastings was just resigning and a new placement – new recruiting was carrying on, and he was one of the candidates who came through Minnesota and had quite an impressive – as he is – impressive interview with all of us.

CS: He was a pretty amazing guy.

DC: Amazing guy.

CS: Pretty amazing guy, absolutely. His vision and mentorship skills and all of those things above and beyond his organizational and visionary views of psychiatry were very important to a lot of us.
DC: He’s had a broad spectrum of interest and approached it from multiple facets.

So then, in your residency, tell us how things turned out to be there.

CS: So I got to be a resident, and back then, you may remember, there was this whole thing back and forth about do psychiatrists need internships, and Jolly said – “Oh, for God’s sake, they absolutely do.” But everybody else was getting straight internships like medicine, pediatrics, OB, etc. So, he invented UCLA’s internship, and I got to be in the first class. He said, you have your whole life to learn psychiatry, so no psychiatry in the first year. So we had four months of peds, four months of neuro, four months of medicine. I was in kind of a test run. There were just three of us who were psychiatry interns and he just put us in peds, put us in internal medicine and inpatient neurology. My first four months I was like a neurology resident for four months on the inpatient ward.

DC: Well that was prescient, that was a smart move.

CS: It sure was.

DC: That sort of gave you grounding in medicine.

CS: It gave me an appreciation of the importance of the PGY-one year, which I think we’re very fortunate here to have really good abilities to do things in medicine or peds or neuro, and stuff like that.

Second year, inpatient; third year, six months on child and adolescent inpatient, and then our CL service, Dr. Pasnau being really interested in consult and liaison, and I bore the faculty to death about this old story – What we would do on our rotation – you would be assigned to a ward, and you would make rounds on that ward with the team every morning – so I’d come in at 8 o’clock, meet the neurologists, we’d walk around the ward, I’d have a little white coat on with all of them, and we’d decide who needed a consult, who didn’t, etc. Then in the afternoons I’d come back and do the consults and stuff like that. Of course, I was learning a ton of neurology above and beyond what I’d learned as an intern, and it led Dr. Pasnau into this idea where he had people who were doing dialysis. They’d be specializing in dialysis in consultation. OB-GYN, post-partum depression, all sorts of … When the consultant went to the ward, it wasn’t the beeper went off, they run over there and they show up and they go – Geez, I don’t know much about depression during pregnancy, I don’t know what to do. You’d just do a consult. You were one of the members of the team. I still really like that idea. Whether it can work in this day and age, I don’t know, but I still think that was a terrific experience.

DC: After your residency, where did your career go?

CS: An interesting thing happened at the end of my PG-3 year, next-to-the-last year, our new training director, a guy named Joel Yager, asked if I would be the associate training director for UCLA residency. What an honor! He was quite a guy. I enjoy teaching, and I kicked it around with him, I thought it over, and I said, I’m not sure I know enough to teach anybody anything.
And I'd been a Falk Fellow at APA and had bumped into a few people who were applying to be clinical associates at NIMH [National Institute of Mental Health], and I thought I'd make my decision by applying for that position. If it didn't work, then I'd stay at UCLA and stay in teaching. I got accepted to be a clinical associate at NIMH – it was a year away – to work on the schizophrenia research unit. So I spent my fourth year as a senior resident for an inpatient ward, oversaw the PG-2s, etc., and fortunately our brand-new attending had just graduated from being a clinical associate at NIMH, and so every week he'd give me some tips on how to get ready to be a good clinical associate, and moved to Washington, DC. – NIH is in Bethesda, [Maryland] – and went on to the schizophrenia research ward, where I worked for three years.

DC: You made some progress there, in terms of your responsibilities.

CS: I think I learned a lot. Obviously, I learned a lot about research, but I got to be the research coordinator, was one of my administrative positions. I was also the ward chief for our twelve-patient inpatient schizophrenia research ward. So I learned how you work with the other doctors and the nurses and your administrators of the hospital and everything like this – pretty darn important stuff. But the major thing I learned, outside of the research, when I finished residency in '77, everything at UCLA, all the wards, were general. You could be on an inpatient ward and have manic patients, schizophrenic patients, borderline patients, sociopaths, after a suicide attempt, anorectic patients – they were all on the ward, and you remember the milieu therapy days, and we’d sit around and we’d try to talk about the unconscious reasons why a person behaved the way they did on the ward. The schizophrenic people didn’t do very well on those wards. So when I was on a ward where everybody had schizophrenia, the whole staff was focused in on how to help schizophrenic people. It dawned on me that what I wanted to do was develop programs for schizophrenia, not just move on to a university and work on a general ward somewhere.

Turned out there was a guy named Bob Friedel at Medical College of Virginia, and he had a somewhat similar idea. So he put an ad in the paper when I was a second year clinical associate saying that what he was trying to do at Medical College of Virginia is to develop a specialized program in mood disorders, [and] a specialized program in schizophrenia. I interviewed and I got the job. I was able to start one of the very first schizophrenia programs in the US in 1980 at Medical College of Virginia. Everybody on the team had schizophrenia. On the inpatient service where I mostly worked, we had follow-up clinic for schizophrenia, collaborated with the City of Richmond and their day treatment center and with Central State Hospital just down the road from Richmond. So I had the ability to begin to learn with the Chair’s support how to start a clinical program that focused in on an illness that had its own special needs. Occupational therapy, needs assessment, medications, etc. So that was a pretty rapidly developing time. I was there for about three, three-and-a-half years.

DC: Then what happened?

CS: What happened after that is I was at ACNP [American College of Neuropharmacology], after about being there three years, and Dr. Tom Detre, who was head of psychiatry at University of Pittsburgh – They had developed the schizophrenia module about the time I was developing the program at Medical College of Virginia. He asked if I would come and be the medical
director for their schizophrenia module. It was right about the time he was moving up into a new position at the university and David Kupfer was becoming chair at University of Pittsburgh, and they were right at the point of becoming the department with the largest amount of NIH grants in the U.S., which is a leadership characteristic they still have.

DC: It's remarkable, what they've done.

CS: And so, I felt that I would be in a position to be with a leading department, and they have lots of people to collaborate with, etc., and so I thought that would be really a good step, so I moved down there in 1983. Moved up there from Richmond and became medical director of the schizophrenia module.

DC: And for how long were you there?

CS: It turned out I was there for about three years, and it was pretty challenging. They had not really had a big background in schizophrenia research. Dr. Kupfer had been mostly doing mood disorder research, etc., and I would have to say, looking back, that although I got a lot of research done and our program matured, that it was not a very good time for me. I was running the module, but it just didn't go really the way I wanted it to go. While I was there, Senator [Peter] Domenici from New Mexico had approached the NIH director, Sher [Shervert] Frazier, and he was concerned that the NIH was not doing enough for schizophrenia. Senator Domenici directed some funds to the NIH on schizophrenia, and something called a National Plan for Schizophrenia Research evolved. I was recruited to come back to the extramural program, not the intramural hospital, but the extramural program, and be part of the plan for developing schizophrenia [research] for the country. Seeing as I felt like I was kind of grinding at University of Pittsburgh, but not getting along the way I thought I should, this seemed like a pretty neat opportunity, and I was back in DC for another three years.

Some interesting things happened. Having been at Pittsburgh and Medical College of Virginia, pulled together community resources, specialty wards, being really engaged in schizophrenia at a time that most mentors would say don't go into schizophrenia, it's the dead end of academia, to be at NIH and have NIH say let's really get going on this, provided some amazing opportunities. In three years there, not to be overly narcissistic about it, but I was given opportunities that were just, looking back, pretty amazing. I started the International Congress on Schizophrenia Research: It's the major international science meeting, to this day. We started with 175 people at our first meeting. We meet every other year and now 1,500 people from around the world come to each meeting. We have a young investigator program and Carol Tamminga and I co-direct it and we've published, I think, two books from the meetings, and the proceedings are frequently either in Schizophrenia Bulletin or Archives of General Psychiatry. That was a lot of fun. Just kind of, there wasn't anything there and Carol and I created it. So that was kind of neat.

I started the National Institute of Mental Health Public/Academic Liaison [PAL] Program – In other words, how do you bring programs for people with serious psychiatric illness – how do you get the state hospital and university together. Well, how about creating a funding mechanism for say University of Minnesota and Anoka [Regional Treatment Center or "State Hospital"]? How could you get them to collaborate and maybe do research on outcomes or new interventions or
something like that, and so the PAL program started about a year after I was there and is still going. I got a Public Health Service Medal of Commendation for creating that program.

Lastly, I started a project that is also still going, even though it’s about 25 years ago, along with Elliot Gershon and some others I created the National Institutes of Mental Health Gene Bank.

DC: Tell us about that.

CS: This was a time when we were finally able, by taking a look at the chromosome in ways that we couldn’t in the early 80s with the little small parts of the chromosome and do linkage studies. So, you may remember there was the linkage to bipolar disorder in the Amish community on chromosome 5, etc. So we created a funding mechanism. I developed the contracts for storing the samples to study bipolar disorder, Alzheimer’s [dementia], and schizophrenia. Nine universities around the country applied and got the grants and then they would assess people, develop the interview schedules, etc. Their blood was saved, and then other people could do whatever studies they wanted. A number of the first genome-wide scans were done on that sample, actually. So I had a pretty good time there, learned a lot about administration. I moved up and became the Chief of Schizophrenia Research Branch while I was there and was able to do these programs. It was very, very rewarding.

DC: That’s remarkable. Got your stride there.

CS: It was a very, very fast-paced time. No doubt about it.

DC: The next move then was to …

CS: Cleveland, Ohio. To dig down a little bit below the surface of history. Case Western Reserve University had been led by Dr. Douglas Bond, an old pal of Dr. Hastings’. They were in the crew of people who had been in World War II and understood the impact of psychiatry. Dr. Bond was an enormously popular, charismatic, and energetic guy. He created the Hanna Pavilion, which is their 80-bed psychiatric hospital on the campus of Case Western, and as you may know, at the age of 65, walking to work one day, he had a heart attack and died. The department had an interim for a few years, and then that person became the full chair, Dr. [Douglas] Lenkowski, and when he retired, they began looking for a new chair and Dr. Allan Schatzberg was going to take that position, and he was in Boston. It turned out his wife became ill and he felt he couldn’t move. The dean said, geez, we’ve done this search and what are we going to do and, it’s been three years without a chair, and the search committee guys, just go have lunch. I’m going to take over and figure this out. So he interviewed a bunch of people in the fall and Herb Meltzer recommended me to be interviewed by the dean, and I had worked with Herb on developing the PAL project and [NIH] schizophrenia research, where I’d known him for years, etc. Dean Berman and the president of University Hospitals in Cleveland thought I might do a good job and I was offered the position in 1989 and moved up there in July of ’89 and worked there for ten years.

DC: How did that turn out for you? That was a pretty new position.
CS: Yup, and I’d not been a vice-chair of a department. I was 43 when I took the position. Old, compared to when Jolly West started being a chair at age 29, ...

DC: At Oklahoma.

CS: At Oklahoma. Still have a lot to learn. And so I think in many ways goals that I had helped the department of psychiatry a lot. We took a hospital that was pretty much general. There were five floors, first floor was office building, administration, and clinic, and with the help of the university hospital vice president, we made each floor a specialty floor. You’ve heard this theme of specialty through my career, and I believe in it strongly, so we converted the hospital, second floor, gero-psych. Internal medicine people rounding with us, behavioral neurologists, and gero-psychiatrists. Third floor, Herb Meltzer had already begun developing into what he called the psychobiology unit. We served people with schizophrenia. He ran a lot of his Clozapine trials on that unit, he had a clinic for follow-up of the Clozapine patients and the fourth floor, after I got there, recruited a young guy named Joe Calabrese in bipolar disorder and he developed a mood floor.

So that was a pretty major development for them, and I think what it did and is related to what I even thought about doing when I came here, was by having these specialty programs it provided good care, good teaching, because if you want to learn about mood disorders, as a med student, you’d like to have an expert in mood disorders teach you about mood disorders, so Joe Calabrese would tell people about bipolar disorders. He was a world expert at bipolar disorders. Stuff like that helped, plus, the programs then were useful in the integration with the NIH and/or medication studies that were going on at the time.

So we were full all the time. We had these specialty programs. I think, also, the leading child and adolescent program was all ambulatory at that time. We were able to substantially increase our NIH funding, etc.

Part of the difficulty there, and challenge, and I think you’re probably familiar with that as you live here in Minnesota, was as we were doing all of this development, the wave of managed care for psychiatry hit our region, and our region was highly competitive. Cleveland Clinic, University Hospitals, Metro Hospital, Mount Sinai Hospital, etc. – There was an assessment, there was an over-capacity in psychiatry beds and beds in general, and it was difficult for a psychiatry department in that time to continue being an academic department with the financial challenges of managed care. I know I learned a lot in administration during that era. We were fortunate to be able to maintain the units in the research programs that we had, but we had to do some down-sizing and other things like that to balance the budget as the school and the hospital cut back on their support.

DC: Yes. Well that kind of problems continued from the 80s and 90s even to the present time.

CS: Before we say anything about university – like starting here at the University of Minnesota, having that experience in the mid-90s did allow me to say – I have done this before – when the crash happened here and the state had to pull its resources away. It was not a brand-new experience. I had been through that with administration, with accountants, etc., and it’s been
horribly hard on the faculty here. I greatly admire how hard they’ve worked to overcome all of this, and it’s painful, but I think that if you’ve not had a challenge like that in your life, in your career, somewhere, some way, to be able to figure out how to deal with that, it either takes longer or can kind of go all over the place, or something like that. I think that experience helped me when we had our crisis.

DC: A link before. What attracted you to Minnesota?

CS: There are about two-to-three things. The first is, at the end of nine years at Case Western, I came home from work kind of a May afternoon. My wife and I were getting some dinner together and stuff like that, and talking, and I’d gotten some letters to apply for being chair in some larger departments in Case Western, and we began to talk about if I ... and I had no wish to leave and no wish to move and look, because that’s disruptive to a department in my experience. But we decided that if I didn’t take a look at something, that, within a few years, if I thought about doing something else, I might be too old to do it. So I responded to some of the ads and was asked to look and stuff at some places. I think I bumped into Paula Clayton [Psychiatry Chair At University of Minnesota] at APA [annual meeting] that year and she said -- “Oh, you know, I’m going to retire and there’s going to be an opening -- what do you think about that?” And I think David Dunner, an old pal and good friend of Paula -- always been a very, very good friend of mine -- said, I’ll nominate you. And when I got up here -- we haven’t talked much about that I did some research, also, along the way, but I’d been doing brain-imaging research, and when I got here and met Apostolos Georgopoulos and Kamil Ugurbil and saw the CMRR [Center for Magnetic Resonance Research], and that both of them wanted to work with the Department of Psychiatry. Famous phrase -- well, semi-famous phrase -- I use here -- How many people had been imaged at the CMRR by faculty in the Department of Psychiatry in 1999?

DC: The answer is zero.

CS: Zero. The Department of Psychiatry now images more people in CMRR than all other departments on the campus combined. We’ve been fortunate to have just an amazing team of people interested in using -- this is an internationally renowned resource here. I’d kind of felt that I’d reached the plateau of where I was going to go in the imaging research at Case Western. And the grinding of the financing, some things like that, I said, you know, ten years – Minnesota has a very nice set-up. Case needs a new person, and so I thought that it would be time to move.

DC: There were advancements here already in place, and that probably appealed to you, and you could see that you had leaped forward, almost, with the facilities here.

CS: Correct. There was another thought that I had in my mind, quite consciously, and I talked with Dean Alfred Michael when I first visited, and that is, having been a chair for ten years, I felt I had recognized where the problems and issues could be, how to constructively engage when there was an issue, or how to execute a strategic plan, how to organize a department, how to deal with finances. I’d worked at NIMH, I still knew a lot of people there. I thought I had the experiences that would lead to being a good chair and help the department move ahead.

DC: Well, that was our luck, that was our gain.
CS: It goes both ways.

DC: I was part of that …

CS: You were on the search committee.

DC: … and I am so happy that I could be in on that.

CS: I remember you had, during that recruitment phase, a reception down at the Minneapolis Club and you invited people from the VA like Maurice Dysken, and psychiatrists from the community, and you had a wish that psychiatry would reach out to the community more than it had, and that was quite memorable.

DC: That was a good time, had a good feel to it. I remember. So you came, then, and tell us now what you see has happened since you’ve been here and kind of where we’re at now and issues we’re facing.

CS: In the number of visits I made to come here, learn about what was here, talk with Dean Michael, administrators, faculty, Apostolos, etc., I developed an idea to focus our academics on imaging, genetics, and clinical trial research, and the rationale for that being we had one of the greatest imaging centers and that’s what the NIH wanted to do. Genetics were emerging. There hadn’t been a person imaged in CMRR, there hadn’t been a blood drawn for genotyping in the department, and I said – We have to get going in these areas. Both of those areas, I thought, could interact with doing very good clinical trial studies, and I felt a university department was very important for the faculty involved in what was the latest things happening. My experience at Case, especially working with Herb [Meltzer] and with Joe Calabrese, were that the participation in the clinical trials of new compounds led our faculty to be expert in them, basically the day they were approved. I thought also that by doing very good clinical trials, we could use those results in an interface with imaging and in genetics. So, like Dr. [David] Mrazek at Mayo says – “Let’s draw your blood and find out what’s going on in your serotonin or your transporter genes or your metabolic genes and that’ll help us with your treatment. The same is also true for imaging, where we’re now imaging at baseline, giving them medicine, imaging after the study is over, and seeing where does the drug act in the brain. Or, can we tell who’s going to respond and who’s not going to respond. So the interplay was actually more important than the three items of imaging, genes, and clinical trials.

Then I thought, and this has been challenging, but is beginning to emerge, that in order to have good schizophrenia programs you would need to develop good specialty programs, but now you know the 20 or 30 years of my history in that, that if you’re going to do good schizophrenia research, you have to have a good schizophrenia program. If you’re going to do whatever kind of research – Gail Bernstein has very nice childhood anxiety program here. She has had federal funding to examine that. Jerry August has a terrific program in childhood prevention. But, you’ve gotta have a program, not just an individual. So that was the second part of the strategy. The first was imaging overlapping with genetics, overlapping with clinical trials, you have the
specialty programs to make sure that we could take care of people that might want to be in research.

So I think we got that going. We were able to bring in some people, like Dr. Calvin Lim joined us. Dr. Tonya White, a triple boarded person. She really got things going in imaging of young people. Jeff Wozniak, who now works with fetal alcohol syndrome. Calvin’s background – I met Calvin as a fellow at Stanford in the late 80s—and we had been friends over the years. I was really fortunate that he could also see the potential of the CMRR, because his program has grown and he’s infused imaging into so many aspects of what we study, from adolescent mood, fetal alcohol syndrome, impulsive behaviors, schizophrenia, etc. He’s just an amazing person here to advance this kind of research.

Interestingly enough, with focus of discussion on our research, the Department of Psychiatry has tripled its NIH grants in the last ten years, at a period of time, the last five years of which the NIH budget’s been almost flat, and so to have people like Marilyn Carroll, Calvin Lim, Jerry August, Hossein Fatemi, among others … Scott Crow, etc.; Nancy Raymond, getting federal grants. John Brandt is just been … I think that’s pretty remarkable in this period to triple that income.

DC: In comparison to other major universities, we rank quite high on the amount of federal grants that we get. That’s really quite commendable.

CS: We rank higher than we did. We are now 25th out of 135 medical schools, and that puts us in a good position, but we still have a ways to go. We went from 39th in 1999 to 25th now, and we tripled our NIH funds and expanded the breadth and scope of what we’re able to do. But I’m hoping we’ll be able – especially with a new president of the university, new dean of the medical school, and MMF [Minnesota Medical Foundation] campaign in the neurosciences to take it up a notch, and move up maybe another ten spots.

DC: What is your general view, or what are your hopes, or what direction are you taking the department in now, given that we’ve arrived at this point.

CS: I think our department has advanced in the last 11 years in its national reputation, and, thanks to you and your colleagues like Deane [Manolis] and other of our clinical faculty – You know we had fifteen med students in the last graduating class go into psychiatry. You know the number of med students that were going into psychiatry ten years ago. Not a lot. So, I think we’re getting better and better residents, two graduating residents joining the department of psychiatry this last year, Dr. O’Sullivan, Dr. Nelson. They are wonderful, and I think if we can keep this moving, I believe we’ll be able to have just amazing faculty as we go forward.

The next thing is, as you are probably aware, from all of the stuff that comes out of [Academic] Vice President [Frank] Cerra’s office, and things from the University of Minnesota Physicians, the idea that the med school, the practice plan, and Fairview Hospital have to get on the same page if they’re going to be an academic medical center. They can’t do it in three cycles. So that is a major strategic thing going on now. At UMP meetings, chairs meetings, meetings with the dean, meeting with Mark Eustis, the CEO of the Fairview System, I am always describing the
importance of how psychiatry has to be in this program, that it be viewed in the same way that they would view internal medicine, pediatrics, etc. I spend day and night working to make sure that psychiatry is involved in a model of an academic medical center, just like you would develop surgery or medicine or cancer.

DC: Front and center, a seat at the table, of prominence.

CS: The potential here is enormous. That was one of the reasons I thought about coming here. A 180-bed hospital, day treatment, clinics – I mean it’s just amazing, the resources here. It’s just how do you pull it together. The ingredients are here, it’s not like we have to go out and build a big brand-new hospital (though that would be nice), but what we just need to do is figure out how to do it. So that is probably the number one priority.

DC: Enhance and secure the position of psychiatry in the medical school in the academic setting.

CS: We have to make it an academic medical center, that’s our challenge.

The next thing is we, as I think you know, have been looking a lot at programs, and we have a first episode schizophrenia program. Jon Grant’s developed a behavioral addictions program, [and a ] gambling center, he has here. We are developing some clinical programs. We have a nice little program in borderline personality disorder. People in that team are now actually training the nurses on Station 20 on how to use DBT [Dialectical Behavioral Therapy] in the inpatient setting. We’re getting going. It’s not just a single office-based person saying – Oh, I like to treat mostly eating disorders, I’ll do that on my own. Our programs are coalescing, and I’m hoping to be able to do that even more. I think we need to expand our ability to help people with depression and especially help people with bipolar disorder. I think that’s an area we need to grow in.

DC: Particularly the resistant patient.

CS: So, become an academic medical center, develop within this thrust the specialty programs that I think will continue to keep our research going, and to maintain the momentum of how you and I have worked together so that we see med students right away, and we get them engaged, we collaborate with the psychiatry interest group, make sure they have a good clerkship, and that they want to pick psychiatry, because our state, as you know better than I, is actually below average in the number of psychiatrists per hundred thousand in our state, and child psychiatry is even struggling more.

So, I can’t thank you and your colleagues enough for the clinical faculty dinners you’ve put on and your allowing the students to shadow them, because what I’ve learned, and I know I can make mistakes as well as make things work, the psychiatry interest group, when I got here, I thought – They’ll be so delighted with all this great neuroscience we can do. Let’s give them a wonderful lecture on brain imaging. It didn’t work. They wanted to see patients. They wanted to see people with psychiatric illness. They come and shadow you, then they want to be a psychiatrist. They go over and see the 3 Tesla magnet. We may have gotten two-to-three people to go into psychiatry because they thought the magnet was really great, but you got fifteen,
working with people like Corey Jacque and Susie Jenson and stuff like that. We want to keep that momentum going.

DC: The difficulties around the industry-psychiatry coalition that has been controversial throughout the country – what is your take on that and where are you headed in issues around that, the issue of conflict of interest and such things?

CS: A difficult and challenging topic, and I think I mentioned earlier that when I came and drew up a strategic plan for our department and worked with Dr. Cerra at the AHC [Academic Health Center] and with Al Michael, I strongly felt that a Department of Psychiatry should be able to be involved in clinical trials to advance treatment and to be very familiar with medicines as they came out. I felt that patients need to be well cared for and highly respected, so with Dr. Cerra and Dr. Michael, I was able to get as part of my package to come here the resources to build the ambulatory research center. And this is in our professional building, it’s 5,000 square feet of space devoted to clinical trials, to assessment for imaging studies, etc. The interview rooms are nice, they have a window, etc. There’s a wonderful reception area and each person who comes to be in the research, is greeted by a person. They have a little area for children to sit if they are going to be in the clinical trial, etc. Exam rooms, conference rooms, the whole thing.

During the 90s I think there were some issues that arose that fed the controversy about the relationship of departments in medical schools, no matter what department, and I think you are aware of even amazing universities like Duke and Johns Hopkins having issues where they even closed research for periods of time because of things that went on. During the last decade, there have been a number of ingredients in my mind leading to very substantial publicity around problems in the relationship of industry to psychiatry – maybe the most visible – but orthopedic surgery and other places like that.

DC: Implants and stents … regulators …

CS: Implants and stents … joint replacements, spinal surgery, but psychiatry, boy … front page in the New York Times for even the president of the American Psychiatric Association – grilling, nasty things. His university investigated him thoroughly, and he had done nothing wrong. As a matter of fact, what he had done is he had done exactly what the president of Stanford had asked him to do. Dr. Schatzberg. So, in my impression, looking at this, there probably are some instances of the high-flying industry utilizing academia in ways that was not fully appropriate, that the new guidelines for managing conflicts of interest and improving transparency are very, very appropriate in my mind. I think they, if followed in the way that I think our university has put forward and the way Dr. Cerra has expressed his wish, he, from the first day I met him to now, has said – I want us to be able to collaborate with industry, whether it is pharmaceutical or device, or whatever; but, let’s make it real clear what we’re doing. I think we can move ahead with this. And our conflict of interest policy here at the University is really pretty much that way. Not pretty much, very much – it’s actually as strict as any conflict of interest in the US.

Our Department of Psychiatry has been hurt by an event that happened in 2004, when we were involved in a study of first episode schizophrenia. Dr. Jeff Lieberman, the chair now at Columbia, and a real expert in first episode schizophrenia, thought to himself, and his colleagues
like Joe McEvoy and others, that we really don’t know how to use anti-psychotics and/or compare the efficacy and safety in people right at the outset of the disease. So he wrote a protocol and submitted it as an investigator-initiated study to AstraZeneca, and it compared Olanzapine, Quetiapine and Risperidone blindly. And Dr. [Stephen] Olson, here, is the head of our schizophrenia program and was the PI [principal investigator] for our site. The study entered, I think, 400 people.

There’s lots and lots of descriptions of what happened, but Dr. Olson enrolled a young man. I think he got enrolled in November, and in May ended his own life. He was at a residential treatment center. He had been seen by a staff member maybe an hour or two before his death, and Dr. Olson was coordinating the ratings and the administrating [sic] of the medication while the person was receiving treatment in the community. This, then, led to, as I think you’re aware, a lawsuit. The lawsuit was dismissed by the judge, here in Hennepin County. I was accused of not overseeing the case appropriately, and that I had been an advisor for AstraZeneca, so why did we have this grant from AstraZeneca. Although, Dr. Lieberman was the person that did the study, was the [overall] PI, and was running the study. The judge dismissed the case, with prejudice, saying that the case was so feeble that he could not allow for an appeal. And since that time, there have been a number of different people, including a person on the faculty of the University of Minnesota, in the Ethics Department, the patient’s family, very distressed and upset. The department has gone through--- the department as a whole, has been audited and reviewed. Dr. Olson has been audited and reviewed, and I’ve been audited and reviewed by the State of Minnesota, by the vice president of research office, by people from the Board of Regents, from the State Medical Board, from the Attorney General’s Office. All of those [have been] negative. Yet, as people continue to bring up these complaints and go to the newspapers, it continues to be in the newspapers.

It’s very difficult. Very difficult. It’s led me, obviously, to question our strategies for our department. [I’ve] talked extensively with Vice President Cerra, with Executive Vice Dean Paller. Each month we have a brown bag [lunch] in research for our department – where are we going to go, what are we going to do – and we feel that it is very important to continue to do good research, and that industry are the people that are making the new compounds and we have to – under the guidelines of conflicts of interest – continue to be able to test new treatments.

DC: That, of course, has been a long history at Minnesota, from the discovery of Thorazine in 1953 to its testing and comparing with other major anti-psychotics over that whole period, done originally among all other institutions here at Minnesota, with the ECDEU, Early Drug Evaluation Project [Early Clinical Drug Evaluation Unit].

CS: That’s correct.

DC: Burt Schiele heralded [headed it], he was full-force in the 60s, 50s, even.

CS: Actually ECDEU got changed over to NCDEU, New Clinical Drug Evaluation Unit, instead of Early, but Schiele was one of the founders of that group. It allowed for really excellent development of methodologies for clinical trials and the rapid testing of medications, so it was really excellently done, so there is a long tradition in the State of Minnesota.
This has been very challenging because on the one hand a person could take an approach of -- This is so icky let’s not do this anymore. But one could say, on the other hand, if you’re an academic department of psychiatry, it could be considered your responsibility to be involved in providing the best sort of testing that one could for new treatments, or to have an idea about a medication and submit a grant as an investigator-initiated grant. Not a grant given to you by a company, but you submit to them, they have their own board of review, it’s your protocol and you run it from here.

So, I’ll cycle back for a second. Clinical research. Why would one do this? So I showed up at the NIMH in July in 1977. Two weeks before, a guy named Dr. [Herbert] Wagemaker had just published a case series in which he reported that people with schizophrenia who received hemodialysis had a recovery of their psychosis without antipsychotic meds. My branch manager, Dr. [Benjamin] Biff Bunney, said we have to test this in a controlled trial, because if it works, it’s amazing. If it doesn’t work, we need to make sure that people do not get dialyzed if they don’t need to. And so, I’d been at NIMH two weeks, Dr. Bunney, Dr. [Daniel] van Kammen and I are down visiting Dr. Wagemaker, and I designed and set up the double-blind hemodialysis trial, and we demonstrated it doesn’t work. During that time, I would get calls all up and down the East Coast. Nephrologists were saying “Hurry up, please finish this trial. I do not have room to dialyze my kidney patients because so many schizophrenic people are being dialyzed in our community.” It turned out it didn’t work. The point being for academic centers to do appropriate clinical research is crucial for us, so we don’t go down some avenue of uncontrolled research getting out into the community and people getting on things that there’s no data for it to work.

I know we’re way past our time. You’d asked me some questions about what was I thinking about when I came, was I thinking about even when I started at Case Western. I feel that a department of psychiatry’s responsibility to its community and, if you will, to the collection of med schools around the country, is to do applied research and to do it well and at a high standard. And I think that’s something that I will stick to, and I’ve been very pleased at the university’s support, for us to have good conflict of interest, but to continue to do good clinical research.

DC: We certainly support that effort.

CS: Well, thank you. And thanks for spending the time to come by and visit me and talk about all these things over all these years. Thank you a lot.

DC: Oh, you’re very welcome. Thank you.

[End of interview]

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