

**Harry H. Bird, Jr. M.D.  
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President of Hitchcock Clinic, Emeritus**

An Interview Conducted by

Daniel Daily

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INTERVIEW: Harry Bird

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DAILY: Today is December 17th, 2002. I'm speaking with Dr. Harry Bird this morning. Dr. Bird, the question I'd like to start out with is what circumstances or people in your life led you to pursue medicine?

BIRD: A combination of good luck and good friends, really. I was born and raised in Wakefield, Massachusetts, and went to Harvard College and then on to Tufts Medical School. I had known pretty much, I think, since high school age that medicine was very attractive to me as a career and was fortunate to be able to get into medical school. Then, with the support of the navy, did my anesthesia training in Boston.

When I finished my training, I had to spend some time in payback years to the military, and during my time at the naval hospital in Boston remained close to a person who was a mentor to me, Dr. Robert Smith [Robert M. Smith '34], who was a Dartmouth alumnus and for many years was the chief of anesthesiology at the Children's Hospital Medical Center in Boston. In fact, my career goal was to join Bob Smith and practice in Boston in pediatric anesthesiology. At the time I was getting out of the navy in 1963, there were some administrative problems, I guess one could say, going on at Children's Hospital, and it was not the time when they were going to be bringing on new staff. Unlike the way things happen nowadays, mentors in the '60s in medicine still said, "I'm sending you someplace." And Bob Smith said, "I'm sending you to Dartmouth." Since my wife, Carolyn, and I had spent our summers in New Hampshire as kids and loved this area, it seemed like a good place to look. We came and visited here at the medical center in the fall of 1963 and loved it, so on my release from the navy in early 1964, we arrived and have been living here ever since.

DAILY: So '63 brought you to the end of a stint with the navy, and you decided not to make it a career.

BIRD: That's right. I often half jokingly say that when we came to Hanover and to practice at the medical center, it was an interesting transition, and I think I mentally resigned the job every night for about a year trying to figure out what had I gotten myself into.

It was a small, very busy department with four attending anesthesiologists and nine nurses. With one person away most of the time or doing other things, it meant on call every third night and every third weekend, which we did for a number of years. Little by little, as time passed and the department grew and I became more comfortable with the opportunities and excited about it, it was clear that there was no place we'd rather be. And that remains so to this day.

DAILY: What would be some of the major differences between your work down in Boston and the initial years up here at Dartmouth?

BIRD: Mainly, of course, before I came here my medical practice had been in the navy, and that had been in Boston and with the marines at Camp Lejeune in North Carolina. So I had dealt mostly with a skewed population of healthy young adults and their dependents. My medical experience probably was more in the line of obstetrical anesthesia, pediatric anesthesia, and young adult – a lot of trauma. Not that many differences in coming here, actually.

DAILY: Same kind of administrative structure?

BIRD: In Boston I was chief of the anesthesia department, and when I came to Hanover, I was the lowest Indian. I hope I remembered that when I eventually became chairman of the department, because there is a pecking order in every profession and medicine is no different. Sometimes you see things that you would like to change, and it has the speed of molasses on a cold day. It was fun.

I early on took on a major responsibility for what was then our school of nursing anesthesia. I've always enjoyed teaching, and it's always been a part of my practice at the medical center.

DAILY: When you came on at the clinic, were you automatically given a faculty position at DMS as well?

BIRD: Yes. That was never as clearly spelled out as it was in later years, but one of the benefits of the Hitchcock system was in bringing together a multispecialty group practice. There was an opportunity to select and

recruit people who were comfortable with that mode. It's not the only way to practice medicine, and some people would find it very difficult, because whether you talk about condominium living or multispecialty group practices, you have to give up a little bit of your independence to become part of a team of physicians, particularly where you're covering all the specialties in a single group. So, yeah, there were some differences.

DAILY: What kind of a strong initial impression do you recollect about the clinic and about DMS as well in terms of faculty or other physicians?

BIRD: DMS, almost nothing. You must remember, when I came here, it was still a two-year medical school. There were a handful of what I would call stars in the basic science faculty who related to the clinical practice group at the hospital. People like Bob Gosselin [Robert E. Gosselin] in pharmacology, Marsh Tenney [Stephen Marsh Tenney '44], who had come in respiratory physiology, and there were some hybrids like Bob Nye [Robert E. Nye, Jr.] and Don Andresen [Donald C. Andresen], who were fun to know and were stimulating. Heinz Valtin was another person whose interest in renal physiology... The medical school, to me as a young person just coming here... Its only meaning was that there were a number of really outstanding scientists who were around enough that we had a chance to know them a bit, to occasionally attend lectures that they would give. Basically, zero contact with the students because they were busily going through what was then even more of a traditional curriculum of basic science studies and given very little opportunity to be in the patient care setting. That was really sort of off to one side.

The clinic itself, of course, I'll always have strong impressions. I think one of the strongest is that when I came here, there were fifty-three active physicians in the clinic. And in the course of a week, you saw everybody and you talked to everybody. My particular specialty of anesthesiology gave me a unique opportunity to do that. We were in the operating room every day working with the surgeons of all the surgical specialties. We also would be making pre-anesthetic rounds on patients who – almost all inpatients in those days – were going to have surgery, which meant that many of the people with complicated medical illnesses had a Hitchcock Clinic internist or an endocrinologist or a pulmonary medicine person or a cardiologist. And because of our interplay with gathering information to prepare our anesthetic plan, it took an amazingly short period of time till I knew every one of the people with whom I practiced. I look today as I walk through the new

medical center in Lebanon, and it's all I can do to remember which direction to go to get to my own departmental offices up there.

But that was a marvelous feeling. And it was a time when you really could point to one of the values of group practice. And that is, no matter what the patient's problem, you quickly knew who had an interest in that, and there was no difficulty in involving that physician in the patient's care. There were no economic incentives or disincentives. If you had a patient with a vascular problem, you knew that Rodger Weismann [Rodger E. Weismann] loved vascular surgery. And no matter whether it was a patient in orthopedics, or whatever, every one of us knew that Rodger would willingly come and give a consultation on his best opinion of how to take care of that part of the problem. That's very special to me and always will be.

It still exists. It's a little harder to see now because of the massiveness of the clinic structure, but there's still this wonderful opportunity to involve anybody who would be important in doing the best possible patient care for any individual patient. One of my strongest reasons for coming into this practice setting.

DAILY: When do you think, chronologically, that close-knitness and the informality, if you could call it that, giving other consultations, when do you think that became more formalized?

BIRD: Temporally, I'm not sure. I would say it was a sort of a slow incremental move towards the more formal structure. It happened for two reasons, in my view. One was the change in the size of the clinic. There were just more physicians, and it was more difficult. People were busier and there were more demands on their time. There were more procedures and more techniques available for us to use on patients. So the more informal visitation was a little more difficult.

Then there was another reason, and that is that it was during the late '60s and '70s that our residency training programs really began to flourish. When you have formal training programs, which, as you know, have to be accredited by a national organization, the Accreditation Council on Graduate Medical Education, you have certain responsibilities and obligations to those residents to document that they've had certain amounts of training and in a certain reasonable prescribed form. To do that required a more formal structure of interaction between patients and the house staff and patients and the attending staff.

DAILY: So I guess it was about 1970 when DMS went back to having the four-year program, so that was kind of all convened at that point.

BIRD: That's right.

DAILY: That's interesting to pick up. I haven't picked that up before in other interviews. Being away from a large city and being kind of up in northern New England here, were there certain things – didn't it feel like you had resources that you didn't have at your hands in the 1960s when you started practicing up here?

BIRD: From the medical point of view, absolutely not. We were sometimes few in numbers. There might be only one person who had skills in a certain area, but there was never a time when we didn't have access to what we needed to practice medicine, which I believe, overall, was the best available medicine between Boston and Montreal. We've had our ups and downs of comparisons to Burlington, as you're probably aware. There were times, I think, when the University of Vermont and the Vermont Medical School were ahead of us in many ways. That has not been the case in the last twenty years, and I think now Dartmouth, in terms of quality and quantity – plus we didn't have to fight the fight of incorporating private practitioners in the city as they did in Burlington. That was not always a successful endeavor in UVM.

No. I never felt... At times, I would have liked to have had more depth in some areas, but we managed to make it work. I think when the cardiac surgery program started with Dick Cardozo [Richard H. "Dick" Cardozo '42 DMS '48] back in the '60s, that was a tough thing to pull off. You had really one surgeon who was qualified to do open heart procedures, mainly valvular procedures. We weren't doing much in the way of anastomosing blood vessels onto the heart, the so-called coronary artery bypasses of today. There was one nurse who could do perfusion, and it was new. We were sort of flying by the seat of our pants. We were the only place doing heart surgery north of Boston.

It was a great credit to Dick that he kept that program alive. I think if it had foundered, it might have been a long time before it got better. As you probably know, it's one of the areas where we have a national reputation, not only for doing quality heart surgery but for years have led the study of multi-institutions, all the New England programs, to put some strong impact and influence on when it's right to do surgery and when you don't need to do it. I think that northern New England,

particularly, has benefited tremendously from that. That all came out of this, although it started, really, belt and suspenders in one operating room with one heart surgeon and usually one anesthesiologist. Those were very slow procedures in those days. People often said, "Oh, God, another day in the heart room." But it was worth it.

DAILY: What kind of memories do you have of the relationship between the hospital, the clinic, and the medical school in the '60s, before the four-year program came along?

BIRD: My '60s memories are those of a neophyte in Hanover with an intense interest in politics and curious about how personalities related to one another. Probably, there's a bit of revisionism in my memories of those days because of the role I subsequently played as president of the clinic and served for many years on the board of directors of the clinic before I became president.

When I came, we were still in the mode that Dr. Bowler [John P. "Jack" Bowler '15, DMS '17] had organized – and which you've heard, I'm sure, from other people with whom you've talked. Dr. Bowler had been for years dean of the medical school. He was chairman of the board of governors, the medical board of the hospital. He was related to many of the people in town, and the ones he wasn't related to, he was very friendly with. And he had just retired. He was not practicing when I joined the clinic. But again through a stroke of good luck, Jack Bowler belonged to the Rotary Club. I was invited to join the Rotary Club, so I got to know him a bit in his retirement years and have some memories of a few thoughts about his views of the clinic and the medical center.

But, really, it was an organization in which the hospital... Remember, this was before Medicare, so the hospital did quite well because of receiving huge amounts of revenue from two sources in the clinic. While some people were not happy with this arrangement, I think it was a stroke of genius and, over time, served everybody well.

When the original members of the clinic decided to try and pull off this partnership with the hospital, it was very clear that they had a hospital that was in financial difficulty, as you've probably heard from others. Hiram Hitchcock built that beautiful hospital, but there was no money for an endowment. There was no Medicare program. So what resources came in were patient care revenues and a few gifts, fortunately, from people like Mrs. [Edward Daniels (Marianne)] Faulkner, who gave money for the Faulkner Building.

But back in the early days, I think the physicians realized, for our practice to be successful, we have to have a good hospital. The way they envisioned doing that was to cede over to the hospital the revenue rights to the radiology and laboratory departments. Unlike most multispecialty group practices – we would be, for example, very different from the Mayo in this regard – the hospital had revenue from the department of radiology and from running the laboratories. This was a major source of funding, which helped the hospital to grow. Was it a munificent gift from the clinic? Well, you might look at it that way. On the other hand, it was pure self-interest, because by doing that it allowed the clinicians to have a first-class hospital in which to practice. Again, something that's happened over the years and is still happening to this day, a value of the partnership between the hospital and the clinic – and I'm deliberately leaving the medical school to one side for now – is that in any given year or decade, one partner needs more help than the other.

Then it's that partner's job to step up and meet that obligation. Early on, this was an example of the clinic physicians giving the hospital access to revenue. Over time, there are some that worked just the opposite, whereas the Medicare revenues made hospitals rich – and didn't do too badly for doctors, either, for a long time – and changed the whole scope of what was available and what was possible to do and provided money to support residency training programs, which had never been here before. Those had been paid for on the backs of the Hitchcock Clinic for years to a great extent. Those were mutually beneficial arrangements. So there's always been an opportunity to do that.

Now, to make that happen, you had to have people who would work together. Those were people like Bill Wilson [William L. "Bill" Wilson '34], who was the administrator of the hospital for thirty-some-odd years – in fact, I think the Hitchcock's only had three administrators in, like, sixty-five or seventy years – Justin Smith [Justin M. Smith '37], who was the financial officer of the Hitchcock Clinic, and the fact that for a long time the board that made the decisions was really the joint board of governors, which covered both the hospital and the clinic. So it was possible to work out a lot of these details between the various institutions.

The physician leader of the clinic after Dr. Bowler for one year was Sven Gundersen [Sven M. Gundersen]. Sven, I think, wanted to be

president of the clinic and was a highly respected senior internist who, I think, decided after a year that there were better uses of his time than to be president, but since his brothers ran and operated the Gundersen Clinic in Wisconsin, I think he wanted to show them that he could be president of one, too. (Chuckles) He stepped down very quickly, and Jerry Folley, Jarrett Folley [Jarrett H. Folley], became the president and stayed president until – well, let's see – 1973.

Those were people who had close ties to each other. Jerry Folley, president of the clinic, Pete Caveny [Edward M. "Pete" Cavaney '17A], who was for a long time chairman of the board of trustees of the hospital. He owned A. B. Gile Insurance and was married to a Gile. So you see, the names and the families keep coming back throughout all of this. Jerry Folley, Pete Cavaney, Justin Smith, Bill Wilson, all not only colleagues in the town but social friends and neighbors. Those are rare qualities to have in such a large enterprise. It made a great deal of what happened happen informally, but I think for the best.

There's a little railroad station in Lewiston. Do you know where Lewiston is, between Norwich and Hanover? It's the home of the Connecticut and Ompompanoosuc Railway Association, which is a club of twenty-five individuals who meet for no social purpose other than having a good time, but over the years, most of the leadership of the medical center, both hospital and clinic, have been amongst the twenty-five members. There have been lots of issues that were able to be talked about informally and some ruffled feathers smoothed and some compromises worked out. That doesn't happen anymore. We still have the club, but we don't use it for that purpose.

I think a lot got done because people had respect for each other and shared this vision. The vision word, the vision thing, I know, is overused, but there really was a vision here that we had something that was unusual and better than a lot of ways of practicing medicine, and it was a mutually shared ideal, both by those who were on the hospital board and others.

Throughout this time, there were always strong college ties on the hospital board, and that, I think, also helped to make everything come together.

DAILY: Two questions. You said there were two revenue streams coming into the hospital at that time, in this pre-Medicare –

BIRD: Those were two significant ones, right.

DAILY: And patient registration would be the other side?

BIRD: Yes. And that, of course, usually was barely enough to balance the budget. One of the things that is often forgotten when people talk about tax-exempt or not-for-profit organizations is that no tax-exempt or not-for-profit organization can survive without making a profit. The sort of polite word for it is surplus. But without surplus, an institution can't grow, whether it's Dartmouth College or the Mary Hitchcock Memorial Hospital or the Dartmouth Hitchcock Clinic. In the hospital medical care business, balancing charity care and what insurance companies would pay in reimbursement, it was often a pretty tight revenue stream to just barely get enough money in to pay the bills, and to expand was very, very difficult. I look at the radiology and laboratory money as two of the sources, not the only ones, but two of the sources that allowed the hospital to meet its charitable purpose to the region, but also to generate funds to do something more than just be meeting that basic obligation.

DAILY: How were the relationships with the medical school at this point, before the four-year plan?

BIRD: Cordial and non-threatening and non-demanding, and rarely a topic of conversation. There was a Dartmouth College pride in having the two-year school. There was always encouragement from those of us in the clinical faculty, who really didn't – although we had faculty appointments, we didn't do very much for them in return. Some people did. Some people gave lectures to the students and helped with laboratories. People from my department would help anesthetize dogs for certain of the physiology courses. But there was a low threshold of demand for support. There was no financial support, particularly, needed from the clinical enterprise. And we were always happy to have people of the stature of some of those I mentioned around to be available. And we had some interesting educational exchanges. There was a cordial relationship but not very relevant to the day-by-day practice.

DAILY: When they brought the M.D. program back in the '70s, what was the initial impact to the clinic?

BIRD: Total change. First of all, we had to go through the debate of was it the right thing to do. The clinic faculty, I think, were fairly sharply divided

as to which route to take. There were some of us who felt that the Dartmouth Hitchcock Medical Center – which it wasn't even called then, but the Mary Hitchcock Memorial Hospital and the Hitchcock Clinic could be successful and do well in a model like, perhaps, some of the clinics in the Midwest. The Marshfield Clinic in Appleton, Wisconsin, or the Geisinger [Medical Center] Clinic in [Danville], Pennsylvania, where they staked their future on high-quality practice group in a quality hospital but without education commitment.

There were others of us who felt that we had a unique opportunity here to have a full-blown medical center with a medical school. And happily, we won. But it was not an easy battle. I would say there was a naiveté even amongst the most experienced of us in the medical school, in the college, in the college trustees about the eventual impact this would have on the college. It was a long debate. Then the decision was made, and the first thing that had to happen was to bring in a dean. That was Carl Chapman [Carleton B. "Carl" Chapman AM'68], who was my next door neighbor when he came here. I got to know Carl well. An interesting, brilliant man.

### **End of Tape 1, Side A – Beginning of Tape 1, Side B**

BIRD: The first impact was we knew we were going to have a number of students who were going to be in our hospital. Now, they weren't *all* going to be there because, as you know, part of the class was transferred to Brown University for their clinical years. But many of them stayed here. Some of them could be absorbed at the Veteran's Hospital, but most of them were in the Hitchcock system in a building which we had expanded once after the Faulkner Building but which was cramped and already a beehive of activity everywhere, and now we added the students on top of that. The monies from Medicare were enabling the hospital to promote larger residency programs. Each department fostered more residents in training. So the impact was of people everywhere and crowding.

There was an impact on our upper valley patients, who were accustomed to residents but were not accustomed to having medical students being observers or participants in their care, which both slowed it down and provided some of them with the maddening experience for them of repeating their story three or four times. So there were many impacts that were difficult to deal with.

There was an unspoken problem, which eventually reached a serious stage, and that was, clinicians, no matter what the specialty, earned revenue to support the practice group only when they were taking care of patients. As you know, until 1979 we took in all of the funding for the patient care provided by the doctors, and then every doctor was paid exactly the same salary, whether he was a cardiac surgeon or a pediatrician. To this day, there are large constraints on how much... They're not all paid equally now in the year 2002, but even to this day, there are constraints, and it's always been the foundation of a group practice that every specialty supports every other specialty as best they can. Then the funding is distributed based on that principle. It's why you're able to have a physician in our practice group make a decision for a patient which is independent of any financial impact on that physician's personal income, which I always found very comforting. I never had to think twice about what I thought was the right thing for a patient and whether that was going to have an economic impact on me.

When you have a medical school and now have seventy or eighty students and more things going on even in the basic science years and a curriculum which is beginning to tend to involve students more with human beings and patients earlier in their career, you have to have faculty. Who was the faculty? The clinical faculty were the Hitchcock clinic physicians, and when they needed to be lecturing or giving supervisory time to conferences, they couldn't be scheduled to be seeing patients. All of a sudden, you have a problem of revenue per physician being impacted by the amount of time that physicians were away from the direct care of patients.

Making the problem even worse, most of us loved the time we were with the students, so there was never a problem getting the physicians to do that. In addition, we had always had a system in the clinic whereby if you had a reasonable project that you thought would be of an educational value – usually you're trying either to write a paper or prepare conferences or talks – people were given a half a day a week of time to do those things.

Well, we began to realize that we were, per week, providing less patient encounter time per specialist because they were busy doing other things. Not bad things, but they were doing *other* things. "At the same time, the medical school, which I'm sure any Dartmouth College trustee will tell you is an endless sink into which they can pour money forever, and most people around the country will tell you, at least in my experience, that a medical school can eat up the resources of a

university very quickly if you're not careful. Well, the medical school realized it had ever increasing obligations of a financial nature, and the college, in somewhat of a "every tub on its own bottom," really never, ever gave the medical school a blank check.

One of my views of the college over the years has always been that Dartmouth College loves having a medical school and loves the prestige, and in a very New Hampshire tradition, has a good idea and always looks for a way to find someone else to pay for it. That, I think, has – what's the old saying? When they say it's not about the money, it's always about the money? Well, finances were clearly one of the issues that drove all this.

We had this problem of the clinical faculty being sort of torn in two or three different directions and loving it most of the time. However, as the challenge to meet budgetary bottom lines grew, as departments got larger and we wanted to have more residents and provide more funding for various excellent ideas, departments were asked to meet a bottom line and meet expectations. This is where the push-me pull-you began of clinicians saying, "Now, wait a minute. I don't want to work for no salary, I've got to have a reasonable income. You're telling me you want me to do all these educational endeavors and yet you're banging on my door and saying why aren't you seeing more patients, why is your revenue down, and why aren't you contributing more towards your department's bottom line?"

And I'd say that that problem is going on today and will never totally go away. It's one that you have to manage, I think. Each dean and medical center president and clinic president and hospital president has viewed it differently in any given month, but that's a dynamic balance that's always having to be met. It's an allocation of scarce resources. We used to occasionally at the clinic meetings say our motto was leadership through poverty, because we did, for a long time, as you know – until right to the present, the clinical practice group provides large amounts of cash transfusions to the medical school. That's neither good nor bad. It's reality, and it's the way we choose to do business. But it sometimes puts a lot of pressure on the system.

DAILY: While you were clinic president, how did you deal with the issue of revenue versus time with the students?

BIRD: Well, I'll tell you one anecdote. We had a fellow who came to work here in information systems, who is still here, absolutely brilliant person

with computers. The administration of the clinic, who were non-physicians but who were my right and left arms and right and left legs, persuaded me to put in a computerized appointment system in an effort to try and maximize the best use of the physicians' time. And we did.

It worked pretty well, but about three months after it was running, I had a very busy gastroenterologist who also was a very hard worker. He came to me one day and said, "I finally figured out why you put in that system. It's not a patient appointment system. It's a doctor attendance book. It's so you could figure out where we were, because we have to tell you where we are every hour." [Laughter] Well, he was right, and I should have known that I'd get caught.

One way we dealt with it was to be pretty rigid about the assignment of time. We stopped the practice of having guaranteed afternoons off a week. When I came here, every physician took an afternoon off a week. I missed that terribly. It was wonderful. I had Wednesdays off for about the first six years I was here. It was time to do things with my kids and see what they were doing at the Ford Sayre ski program. But we had to do away with some of the benefits, and I don't suppose it matters what institution you're with, taking any benefit away from a group of people is never greeted with happiness.

Also, we were working through a still somewhat unresolved problem, and that is, where did the clinical department chairs fit in the role between the medical school and the responsibility for the clinical practice group. I would guess most of the chairs in my years as president, although we were always good friends, would have given anything if I and my job had disappeared, because most academic medical centers have a dean and department chairs, and they don't have sitting off to one side a president and a board of directors of a, at least technically, for-profit clinical practice group.

I'm sure you've heard from others why the clinic was set up as a for-profit practice group. Dr. Bowler never meant to do it to provide stock dividends. Each of us had one share of stock in the clinic. He did it because the original group was a partnership, and that became a tax nightmare. But when they looked into an alternate form, the only one which would allow them to cover the doctors under Social Security back in the '40s was through a for-profit organization. Although you were a voting member and you had a share of stock and it was technically a stock corporation, there were no dividends, and the stock, when you retired you had to give it back for one dollar. That later

became the reason we converted the clinic, which happened on my watch, because we had all the problems of a stock corporation and none of the benefits. It was a terrible situation, and we had to get rid of it. But that's digression.

The chairs, in a way, did not have the authority unless the clinic board and I allowed them to do anything. That was walking kind of a thin line. During my time as president, I still set the salaries of every physician in the clinic. Now, we did it by working hand and glove with the department chairs. There were only five chairs, as you know. The chairman of surgery would come with all of his recommendations, but he had to start knowing how much money there was going to be, and that was a figure he got from our finance committee and my CFO. Then he would sit down and say, "This is what I think each person should receive." On occasion I would disagree with him, based on the fact that I was still a fully active clinician. One of the things that we always held as a principle in the clinic was there were no doctor administrators, so I was in the operating room and I knew what was going on. It was afternoons and evenings when I put my president's hat on. Most of my president's work got done in the locker room, actually, between cases, talking to the members of the medical staff (Laughter).

There were a lot of issues in order to deal with the economic impact, and part of it was to get the chairs involved. They tend, by the nature of their being, to promote the academic aspects of the enterprise. Publishing, research, the non-patient care. Now, there is no department chair who would say that patient care isn't important. Please don't take that idea. But they're more the advocates for the non-patient care issues. The clinic administration and the president of the clinic is the one who's trying to bell the cat and say that's great. "You want to go over to Parkhurst and get them to write the check, or do you want to sit down with me and we'll talk about what we can do?" (Laughter) So that was part of where it was muddy, and it wasn't clean.

And then we had, simultaneously, the effort to create a Dartmouth Hitchcock Medical Center, which had layered another board of trustees on top of everything else, some of whom, in my view, came with preconceived ideas and contributed nothing to the development of the medical center.

All of those things were going on at once. But again, from experience, I guess, it's my belief that if you can keep governance as an issue and people debating governance, you can get an awful lot done in the meantime. The easiest thing to do is to have people talking about reorganizing, and you leave the main issues alone and everybody got on with their work.

DAILY: We can come back to that one. Well, actually, let's pick that up a little bit now. I've got a couple different threads I want to pick up on. If you could kind of flush that out. If I'm hearing you right, focusing on governance versus reorganization, and the history of DHMC in a way is a history of reorganization, at least from kind of an outside view.

BIRD: I think that from the very beginning of the rebirth of the medical school there were two fundamental views of how we should go. One was the traditional model of a teaching hospital, a medical school, a dean, a group of department chairs, and a clinical faculty which would be organized as the medical school faculty. This is the model you would see in most parts of the country, or at least it was until most medical centers of fifteen, ten years ago realized that the first thing they needed to do was unload their hospitals and get rid of them because it was such a nightmare for them. So there was a strong pressure, in the views of some people, to make us a typical academic medical center.

DAILY: An example would be –

BIRD: Would be any of the – Hopkins, for example. Schools where everything emanated from the dean and the department chairs, and their accountability was to the board of trustees of the sponsoring university, in this case, Dartmouth. That was viewed fondly, I think, by many of the basic scientists, who, by this time, were beginning to feel that the clinical enterprise was benefiting more in the growth of the medical center and that maybe the basic sciences were supported but – well, now, part of the reason for that was the source of money for the basic sciences was really the college, and the college didn't care to put much money up front for that. There were even trustees of the college who, I think, spoke openly about shutting the medical school down. Don McKinlay [Donald C. "Don" McKinlay '37] from Colorado was one, I think, at one point in time. At least that's my recollection.

Also, Dartmouth, I think, has this – perhaps appropriate for them – view that if the medical school puts a Dartmouth College diploma in somebody's hand, well, then the trustees and the college are in charge

of everything. Why should it be any different than the engineering school or the Tuck school? Well, it is different, and it's different because Dartmouth could never have put together and maintained the Dartmouth Hitchcock Medical Center on its own. By the same token, the medical center needs Dartmouth's blessing and support and encouragement and its academic imprimatur to succeed. So we need each other. It's a marriage of convenience, necessity, and it works. But this one group, I would say, wanted to make it the more traditional model.

Another group, mainly those of us in the clinical faculty, felt that we were different. First of all, we were bringing to the table something that very few medical schools had in those days, or hospitals had, teaching hospitals. We brought an entire clinical faculty, salaried, and not individual groups, who provided service. Because in Boston, or other places, for many, many years, the neurosurgeons in the city became the neurosurgeons at the Mass General and were at the Peter Bent Brigham. But they were private entrepreneurs and they ran their own show.

The beauty of what we had to offer to the medical center was an entire clinical faculty, full time, on salary, hired, recruited under the concept of mutual benefit of everybody helping each other and that the amount you put into the enterprise might be less than what it costs to keep you here, but we needed a specialist in endocrinology here, fine. Cardiac surgeons are generating more money than we're going to pay them, some of that money will go so that we have the right mix of people. We felt that the recognition of the superior clinical faculty and the clinical enterprise was equally as important as any other part of the medical center.

I guess looking at the Mayo would be my... We really do have so many ties to the Mayo Clinic, going back to Dr. Bowler and others who went there for their training. And we have Mayo trustees on our board here. Those ties are important to me because the Mayo Clinic has always put the patient at the focus of everything. The typical academic medical center may or may not do that. Some of them never have done that. Patients are tolerated, barely tolerated, in order to provide some minimum amount of training for residents and interns and students, and the whole focus of the medical center is on research and investigation and teaching. That was never to be our model here.

One way of trying to resolve those differences, I guess, was to create a medical center, and it started with something called the Joint Council back in John Kemeny's [John G. Kemeny] days. It was really an attempt to get people to give up some of their autonomy. And that wasn't all bad. We had to do some more of that, I think, to make things work for the future. But there were some folks brought in to flush that out, so-called public members – and later became the Dartmouth Hitchcock Medical Center, and I served on that board for a number of years, ex-officio as president of the clinic – who came with the traditional view, who were very impatient with any group of "renegades," quote-unquote, like the Hitchcock Clinic, that just didn't jump up and salute and get in line and do things the traditional way. We lost a lot of ground in a lot of years spinning wheels while that fight went on.

DAILY: What time period would we be dealing with?

BIRD: It started, I would say, in the mid '70s, and it was coming to a close pretty well by the time I finished as president in 1990. But it went on for fifteen – yeah, '75 to the late '80s. And it's still going on as we sit here today, because this newest iteration, which is very positive in my view, is that we're getting back to where we were fifty years ago, seventy-five years ago, and that is bringing the hospital and the clinic back under... I always believed we were better off before the clinic and the hospital sort of split and bifurcated. That happened in the early '70s when the leadership of the hospital board felt that there were legal reasons why we were too close to the hospital and that we needed to have separate boards and arm's-length. Sorriest mistake that was ever made.

One of the reasons that I admire John Hennessey [John W. Hennessey, Jr.] as much as I do is that John was caught in the middle of some of that as a hospital trustee. He wasn't the leader of the board at that point, but at a time when the two groups were separating. We had some tough arguments over that. But John, as he's done in so many things in his life, over time, saw the value of the clinical practice group and what it really brought to the medical center and became a real advocate for it. His credibility went a long way to moving things in a positive direction, and I give him great credit for that.

Those were the years when it was most difficult. But as you remember, when the whole operation started, Dr. Bowler could really talk to himself and make decisions, but always you had this group of – as we referred to earlier in our discussion – of people in the town and

the hospital and the college who knew each other, who had confidence in each other, and who resolved these issues and one board of governors to deal with that. Then it all split apart.

Well, when you start meeting in separate room, separate things happen. The newer group of hospital administrators came in, all of whom except for Jim Varnum [James W. "Jim" Varnum '62] are gone now. They were of a newer mold and thought that you could administrate your way into anything, and that wasn't the case, so we lost some ground.

Now, to my amusement but mostly to my great pleasure, I see the medical center, that old board, sort of drifting down into really nothing more than a – well, I should say nothing more – but drifting into a very focused role in, perhaps, fundraising. And the hospital and the clinic boards of trustees – because the clinic, as you know, has been now for some years a not-for-profit organization – coming together, sitting around the table, meeting as one group, slowly, by attrition, decreasing its size to a more manageable board. And we're going to be right back and as well off as we were when this whole enterprise started. I think that speaks with great optimism for the future.

DAILY: To pick up on an earlier thread, from other interviews, I've gathered there was tension on the appointment of clinical chairs between the clinic and the medical school about who got to do it, how it happened. Do you have any recollections? This would be early '70s, I think.

BIRD: Yes. I guess in the pure world, the dean at most medical schools would set up a search committee, which would have both basic scientists and clinicians on it, and that search committee would present, depending on how a dean wanted it, either one or a couple of unranked finalists. And the dean would make the recommendation to the president of the college and then also, since the department chairs held that office separately in the college and in the hospital medical center structure, they really had to be named twice, if you will. Again, the person to occupy those positions was important to the dean, important to the educational enterprise, but was equally critical to a healthy clinical practice. I think there were occasions when the choice of a person to be the chair left the clinical departments feeling that they were undervalued in the selection process, and there were a few that came and went as chairs that didn't work out so well.

The chairs were in the unenviable position for them of really having two masters, because they couldn't do much without the support of the clinic president, but they, in their hearts and minds, were accountable to the dean. So it was necessary to try and be sensitive to that, and I hope I was. I tried to be. At the same time, I felt we had an enterprise to protect, because it was the engine driving a great deal of why this place was still surviving and flourishing.

DAILY: One of the things that I mentioned earlier is that, from an outside perspective, the history of DHMC is almost a history of reorganization, at least when you look through the records. One of the time periods that jumped out at me was around 1979 when there was a whole kind of review process around the administrative structure, as well as the fiscal arrangements between the three partners. As much detail as you could flush out would be really helpful, I think.

BIRD: It'll be a little hazy for me because that was at a time when I was not directly involved with those negotiations, but I knew about them. I was on the clinic board at that point. As best I can remember, it was, again, being driven by two things. One, trying to set up a more focused traditional model of control with the medical center board in charge, and also a way to try and preserve the medical school from financial ruin. They were having problems with their bottom line, they were using up their unrestricted endowment. The college was not, at that point, I think, in one of its multi-hundred-million-dollar fund drives.

**[End of Tape 1, Side B – Beginning of Tape 2, Side A]**

BIRD: I think that time in the late '70s was when the clinic first made a commitment to provide – I can't remember the amount, but it was half a million dollars or more per year of cash support for the dean and to take on substantial costs of paying for the department chairs. Here again, it sort of plays back to the problems that were slowly developing, and that is the practice enterprise was being looked at to fund a lot of things that were not practice. And that was creating some financial strains.

DAILY: One of the things I've gathered from talking to folks on the DMS side of this, and I would be interested to hear your reaction, is that the clinic wasn't contributing enough to the entire partnership, but particularly to DMS and what it brought to the equation, the prestige, the residency program.

BIRD: Well, my first reaction is that people who value prestige always put too high a price tag on what they think is – it's a sort of a variation of "I don't get no respect." I reject that. What I do think is that people ought to look at the records, which were open to inspection, and see what the clinic was paying physicians and where the rest of the clinic revenues were going and the fact that there was no bank account. We had no endowment. We've *never* had a penny of endowment in the Hitchcock Clinic. There is some now in the combined medical center, but there wasn't any then. If patients gave money, the money was given to the hospital. There was no pot of gold anywhere, so I don't quite understand why people from the medical school... There's a difference between not having what you want and identifying the person that's supposed to give it to you.

Part of the medical school's challenge, I think, was to have people whose research was supported by grants. I think a careful scrutiny of the total number of faculty and the amount of research dollars coming into Hanover per faculty member would need to be brought into focus before one said that there was inadequate support of the medical school by the clinical faculty.

But certainly it can't be because the clinical faculty was taking the money home. They weren't. When I came to Hanover in 1964, my salary as a board certified anesthesiologist was eleven thousand dollars a year. And in 1979, I'm sure... Well, I may have been making, I don't know, sixty-five thousand or so. My colleagues, even in medical schools around the country, were making three and four times that amount. So there wasn't any amount of money. And we didn't have the traditional sources of laboratory and x-ray money. We'd already given that away. I think that there's a very different view of that from some of us.

DAILY: OK. That's good to hear, two sides of the penny, so to speak. To follow this up then, David McLaughlin [David T. "Dave" McLaughlin '54 TU '55] is credited with bringing – I want to make sure I'm accurate when I say this – bringing the hospital and the clinic to the table and saying, "If we're going to have a medical school, if this whole center's going to work, you need to help pay more." Does this resonate with you at all?

BIRD: Not really.

DAILY: Okay.

BIRD: David did some important things, in my view, that helped us to have this medical center. One of the first was the weekend of Labor Day in 19 – let's see, it would have been '83, I guess, when David became president and I took over as president of the clinic. Actually, he'd been here a little bit before that. I got a call from my predecessor, who said, "You know, we have a chance to buy the Occom Inn, and the Occom Inn is critical to the future plans of Dartmouth College. But we, the clinic, are really feeling the pressure of this medical center governance structure and the fact that the clinicians are not really at the table where everything's being discussed." So my predecessor, Dick Cardozo said, "Maybe I should do this before you take office on Tuesday morning." He said, "We're going to buy the Occom Inn."

Well, David and Paul Paganucci [Paul D. "Pag" Paganucci '53 TU '54] nearly had a stroke. But it opened a line of communication between Parkhurst and the clinic which had been not present. I learned many lessons from Paganucci and McLaughlin at breakfast meetings in Room 101 at the Hanover Inn; some of them painful, some of them contentious, always fascinating.

But David did see the folly of building additions onto the old hospital. Now, I'm sure there are those who will say he also knew that the college had great plans for that north campus, and I don't deny that. But I really believe that in the businessman part of David's personality that he knew that the plan that the clinic was opposing and that was being pushed very hard by the hospital and by Henry Harbury [Henry A. Harbury] and the medical center people was a bad plan. I can only offer my opinion about that. Everybody has to do that. But it was David who broke the log jam by saying that it would be possible to buy the hospital, and it was that twenty-five million dollar possibility that opened up the whole range of discussions to say, "Let's move."

The medical school was *very* unhappy. The dean was apoplectic. Henry Harbury, then president of the medical center, was very, very upset because of this physical separation of the basic scientists, which, to my knowledge, has been absolutely a non-event as far as the horrendous consequences that were supposed to occur when the move... As far as I know, from what I see up here at this end of the campus and what's going on in the Lebanon campus, we're doing just fine. So it never happened. But it took years of fighting and foot stamping and some pretty tough debating to get out of these rather bizarre plans that had been proposed for building buildings on Dewey

Field. I participated in good faith in a number of them and would come home at night saying, "What am I doing? I mean, I really, this is intellectually just not right."

DAILY: Now, is it the town's decision not to grant the permit that also kind of helped?

BIRD: Well, that's the part that maybe belongs in one of those books to be opened at some future point. The ability for people who were of good faith and knew each other in this community wasn't totally gone. The planning board, I think, knew that this was a bad plan. They probably were on somewhat thin ice to reject it.

DAILY: Legally?

BIRD: Mm-hmm, legally. But they did, God bless them. And that was another piece of the enabling actions. One of the reasons they rejected it was that the proponents of the Dewey Field project chose to bring as a spokesperson to the planning board a lawyer from Concord who had, shall we say, minimal sensitivity to the town government of Hanover and proceeded in a meeting I will never forget to lecture the planning board about their duties and responsibilities. I knew when I left that meeting that there would never be a hospital on Dewey Field. He, I think, single-handedly antagonized an entire planning board. The current chairman of the board of selectmen, Brian Walsh [Brian F. Walsh '65, TH '66] was on that planning board. It would be fun sometime to get his views of how that all came to pass.

But it was David and Pag who said this is going to be a huge undertaking. We had some feasibility studies on fundraising because we knew we were going to do something. When we put it all together with this new piece of money that the college would put up to buy the hospital, and with the exchange of land, which was key – land that the clinic owned. We owned quite a bit of land, the clinic did, out where Jesse's restaurant is. The college had land, the town had land, and by making all of those things happen, we got a medical center that you see out there today.

David deserves a lot of credit for that having happened. He was always impatient with the clinic because his college and his dean said, "Gosh, they're always in the way." As a person once said, "If it wasn't for the damn doctors and patients, we could have a good hospital here." And we weren't always right.

DAILY: In this whole mix of the three partners – I guess I haven't referred to the Veterans Hospital, but we may leave that aside for now – working with both Jim Strickler [James C. "Jim" Strickler '50 DMS '51] and Bob McCollum [Robert W. "Bob" McCollum], what are your recollections working with those two deans?

BIRD: I knew Jim more as a colleague than a dean. Bob McCollum was dean most of the time that I was president of the clinic. Bob pretty much stayed in the building where his office was. We would meet on a fairly regular basis and talk. I think he knew that resolution of major issues wasn't going to be with just the two of us sitting in his office and that it was a bigger problem than that. We enjoyed a cordial relationship, but I never felt during my time as clinic president that the major decisions took place between the dean and myself. It usually took place in a different form with department chairs and John Collins [John C. Collins, Jr. '68] and Jim Varnum and myself.

DAILY: How about Jim Strickler as a colleague?

BIRD: Well, you know, Jim's just a great guy. Our kids grew up together, and my son and his son played hockey together. I've known Jim and Peggy since we were here. He's an intense person with a tremendous commitment to give as a physician. A fellow politician. I guess you have to be to be a dean. I think he, at times, yearned for more authority to run his show. I think he was still dean when they had the famous meeting at the Hanover Inn where they were going to decide how to start a new clinic and put us out of business. But I think Jim was too wise to be snared into that kind of talk.

Of course, what also goes on in a small town, I knew everything that was said in that meeting within an hour of the time the meeting was over. It never amounted to anything. There was a sort of a rump group that thought they could rebuild the place, and they thought, "If you couldn't get the clinic to behave, we'll just start a new clinic."

DAILY: And that would be the reason why they wanted to do that.

BIRD: Right. That's why they wanted to do it. I'd say it lasted from after breakfast till just before lunchtime on one day, and then people realized that wasn't going to happen.

Jim, as you know, then went on to do other things, both in community medicine and then in his work in Cambodia, I think it is. An interesting guy who was, I think – of the deans from Carl through the present – I would say Jim probably was the most valuable to the enterprise, for me at least.

Bob McCollum is an epidemiologist and a delightful gentleman who, I think, probably worked hard to be a dean and would have been happier being something else.

DAILY: (I'm trying to decide which way I want to go with this.) You've mentioned a couple of times yourself as a politician, so I think I want to move off into the town side of things a little bit, though I'm sure that was never divorced from your role at the clinic. What motivated you and what did you find interesting in town politics?

BIRD: I grew up in a small New England town in Massachusetts, and I've always been interested in politics in its, I hope, decent sense. When I came here, again just through circumstance more than anything else, there was always an attempt to keep someone from the medical center involved in the town, just as there has been with the college. Something which has had its ups and downs. Many people will remember Gordie DeWitt [Gordon V. "Gordie" DeWitt '60] for his years of being so trusted by the town that he could go to the town and present college intentions and work through the minefields of that. I think in the last year or so we've seen some of the problems that result when you don't have a Gordie DeWitt and the years he took in building those relationships.

I came here in '63 or '64, and about three or four years later, Ron Campion [E. Ronan "Ron" Campion '55"], who ran a store on Main Street asked me if I would serve on the town finance committee, which had usually had somebody from the medical center on it. People like Lou Matthews [Louis B. "Lou" Matthews, Jr.] and John Milne [John Milne '37 DMS '38] had served on it in the past. I said sure. So I served on the finance committee, which, as you know, reviews the budgets of the school and the town, and then became chairman of that board.

Then in the early '70s, John Milne, who was an internist, a long-remembered internist at the medical center, at the Hitchcock, was on the board of selectmen and had to resign. The other members of the board of selectmen asked me to serve as a selectman, so I served for

a year as selectman to fill out John's term and then decided that while I liked being involved in town affairs, that really was not a job that I thought I wanted to pursue.

At that point, Lou Bressett [Lewis J. "Lou" Bressett], who was for a long time involved in town politics, didn't want to stay on as moderator of the Dresden school district, and Lou asked me if I would be willing to fill in for him as president-moderator in the very building we're in right now talking, then Webster Hall. Then I did and enjoyed moderating that meeting. Then Stewart Russell, who was an orthopedic surgeon and was the town moderator for the town of Hanover, moved to Lebanon. We don't change moderators too often. The town likes to have sort of a comfort level with the moderator. Most of them serve thirty years, twenty-five to thirty years. So Stewart and a couple members of the selectmen board asked me if I'd run for town moderator. I actually filled in for Stewart his last year, and I guess I started in '74 as moderator and finished this year – well, finished last year actually. No, this year, 2002. And have moderated all the town meetings and national elections ever since and loved every minute of it.

Moses Freeman from Etna, New Hampshire, was town moderator for fifty years, and at one point I thought I'd like to try and beat his record. Then I realized that that was going to be bad both for the town and for me, so I'm now moderator emeritus.

DAILY: Was it ever difficult for you to kind of keep silent when there were certain issues that the town was working on – we could say the Dewey Field issue – when you were moderator?

BIRD: Fortunately, those issues never came to town meetings. I used to think about that. I would have probably had to recuse myself on that because I would have wanted to speak to those issues, but those never got to a town meeting. They were at the planning board level. So I escaped that.

DAILY: I was wondering about that. Anything else you wanted to talk about in terms of Hanover politics and governance?

BIRD: No, I don't think so. It's a disappointment to me that more people don't get involved, and I think it shows. The recent activities to resolve the building of schools here in the town of Hanover I think was difficult in part because of the newness of the school board members.

There was at one point, I believe, a school board where the longest living resident in the town on the school board had lived in town less than four years. The past shouldn't always determine what we do, but to have some sensitivity to the culture and the history of what's happened and why we didn't build a high school up across from the fire station and the golf course and how things progressed to where we are and why John Kemeny started the interstate school district. Some appreciation for that, I think, helps people to make decisions for the future. I miss that now. I sense that.

DAILY: You mentioned John Kemeny and spoke some about David McLaughlin. What recollections do you have of John Kemeny?

BIRD: Wonderful man. Intellect just so incredible. Barely see him through the cloud of smoke. (Laughter) He was the only person that no one had the courage to tell that Hitchcock was smoke-free in the trustee's conference room. He would sit there with his cigarette holder with clouds of smoke around him. (Chuckles)

Played an in-and-out role with the medical center. I think John would have loved it if he didn't have to ever come to Maynard Street to deal with the medical center, but he did when it was necessary. I don't think it ever reached a priority issue for him. He had other more important things. Of course, for a lot of the time he had Three Mile Island. But he certainly had no problem grasping the details of any situation. I always knew if I was going to have to make some comments at a trustee meeting at which he was going to attend, I wanted to be damn sure I had my ducks in a row.

One of the best things that happened to me out of that was I became friendly with Ruth LaBombard, who was his secretary and administrative assistant. After John had stepped down and David was reorganizing *his* office, I had the great pleasure of being able to have Ruth come and be my assistant administrator. Ruth, until her health failed and until she was no longer able to work, took care of our Hitchcock Clinic board of trustees. Just a wonderful, wonderful person. Having that tie to the college was not a disadvantage to me during my time as president.

DAILY: What events led you to become Hitchcock Clinic president? People persuaded you, or –

BIRD: Partly that. It's very interesting. If you look nationally, anesthesiologists seem to – percentage-wise – take on more administrative roles in medical centers. I think it's in part because, while we're an acute care specialty, we have the ability to control our hours more than most people because we don't have an office with patients waiting for us. We also cut across specialty lines, so you get to know a lot of physicians. Anesthesiologists work with non-physician health care professionals on a regular basis, whether that be with certified registered nurse anesthetists or operating room nurses. Anesthesiologists often have become directors of operating rooms, medical directors, and then the peacemaker and resolver of conflicts between surgeons who all want to operate at eight o'clock every morning in the same room.

So there's a sort of a sensitivity, and I think we, as a specialty, have always had more sympathy for the difficulties of being a hospital administrator, and they are difficult. People who have that sort of organizational background tend to emerge as people who take on administrative responsibilities.

So that was part of it. Part of it was just my nature of being curious and liking to do those things and taking advantage of listening to people and knowing people early on in my career here who were in a decision-making position and sort of watching what they were doing. That's how it all happened.

DAILY: I want to make sure I've got my chronology straight here. It was during your presidency, right, that the clinic became nonprofit. Is that correct?

BIRD: Yes.

DAILY: You touched on this earlier.

BIRD: It was a very difficult situation because, as I mentioned, we had the worst of both worlds. We gained nothing from being a stock corporation in New Hampshire for ourselves, nor did we want to. I mean, we had equal salaries. There were no such things as dividends. You couldn't buy or sell stock. We were subject to the tax laws of a for-profit corporation, yet we had no benefits. We also were the only for-profit organization in a medical center of not-for-profit tax-exempt organizations.

But to get from point A to point B is very difficult, that is, to dissolve the clinic and become a not for profit was a horrendous struggle. It was partly a struggle of convincing the physicians to give up their voting rights. Remember under the old system, each one of us was brought in as a sort of a junior member for three years, no matter whether there was a department chair or not, and the clinic membership then voted you in to full membership, stockholder membership. That's about the same as tenure, okay. Although it was not that difficult to reason with a person and, on occasion, ask them to move on. But it did sort of imply tenure.

We wanted to get rid of that. Well, to do that without incurring some fairly hefty financial problems of moving from one to the other was a tough nut to crack. The attorneys for the clinic, Orr and Reno from Concord, Dudley Orr [Dudley W. "Dud" Orr '29], a long-time trustee of the college, and Bob Reno [Robert H. "Bob" Reno '38], a beloved New Hampshire figure, said, "We can't do this for you. We don't have the horses." But Bob Reno had served in World War II in the marines with Randolph Thrower, who was a former commissioner of the Internal Revenue Service, who was the senior partner in an Atlanta, Georgia, law firm named Sutherland Asbill. That firm and its tax partner, Jim Hasson [James K. "Jim" Hasson, Jr.] became the clinic's lawyers with a charge from my board to get us to not for profit.

The first thing we had to do was to accept that it could only happen in two stages. We were going to have to set up a tax-exempt not-for-profit Hitchcock Clinic and find a way to move the doctors into it. That required getting a ruling from the New Hampshire Superior Court that, in fact, we were a de facto not-for-profit organization and, yes, this should be accomplished without any problem.

We had at that point, I guess, a hundred and fifty doctors who were stockholders, and a hundred and forty-nine said yes and one said no. And the one who said no was quite vociferous about not wanting to give up these rights that the clinic owned of certain ways of controlling the future, and with the help of an attorney from Norwich, Vermont, filed a suit against us. In the superior court, we won, and the judge said, yes, you are de facto. We all had to go up and testify.

The one physician appealed it to the N.H. Supreme Court, and the Supreme Court said, "Anybody in New Hampshire knows what property rights are, and those shares of stock are property rights, and you're out of your mind if you think anybody has to give them up. You lose." So

we were stuck. In fact, it was only in January of this year that finally this long process was completed. But we eventually were able to get –

**[End of Tape 2, Side A – Beginning Tape 2, Side B]**

BIRD: In setting up the not-for-profit clinic, Dick Cardozo and I, with help from other people, needed to persuade a group of public members to come and be our first board. Another Dartmouth alumnus, Allen Britton [Allen H. Britton, Jr. '42] from Norwich, a long-time hospital trustee, owned Britton Lumber up in Fairlee, Vermont, was involved with the banks here in town. Allen Britton drove me to Rutland, Vermont, to meet F. Ray Keyser, Jr., K-e-y-s-e-r. F. Ray Keyser, Jr., in 1961, was the youngest man ever to be elected governor of the state of Vermont. He then served on the Federal Reserve Board. Ray was my mentor, my psychotherapist, the most wonderful... He is still chairman of the board. This is, I think, going to be his last year. He's been on there coming on twenty years as chair of the clinic board. The most wonderful, sensible doctor-oriented person with the stature to speak for the clinic, to be an advocate for us in some of the meetings, particularly when we were going through the iterations about the hospital and where we were going to build, and so forth.

Ray came on as the board chair, and then Dick and I, literally, with... Bob Reno had us come to Concord and meet a man by the name of William Oates. Bill Oates was the rector of St. Paul's School, the first non-clergy rector of St. Paul's. We persuaded Bill to come on the board and serve. Dick and I went to New York and met with a fellow by the name of Laird Myers, who was the chief of medicine at the Sloan-Kettering Cancer Institute. One of my best friends from early anesthesia days was Dr. Alan Sessler [Alan D. Sessler '53], S-e-s-s-l-e-r, who is still on the board and was chair of the department at Mayo Clinic and was on the Mayo Clinic Board of Governors. Allen was a Dartmouth alumnus. And Harriett Haller Key, who was the senior vice president of the Chubb Corporation.

Those are examples of people that we brought together to form the first board of trustees of the Hitchcock Clinic. We also brought on someone from state government, Ray Burton [Raymond S. Burton], who belongs to almost everything. Ray was a trustee of the clinic for a few years. And Ann Bradley, representing the community here, David Bradley's [David H. "Dave" Bradley '58 TU '59] wife. That board quickly, because of its quality, thank God for us, attained respect and credibility.

Then the struggle was to get the physicians moved over. That was, from that point on, only a matter of how to walk through the legal problems, and it just took years to do it. It's done. It was no longer a matter of the physicians opposing it, it was just how to get from one place to the other without incurring costs which we couldn't afford. So it has happened, and now all the physicians are employed by the not-for-profit Dartmouth Hitchcock Clinic.

DAILY: Was there some problem with the town of Hanover in terms of the loss of tax revenue for them when you went to nonprofit?

BIRD: No. The issue was raised by some people that maybe the space we occupied in the hospital should have been taxable space, but it never developed into anything. Then, of course, the issues now with the city of Lebanon are a totally different magnitude, but it looks as though those have been resolved.

DAILY: The clinic didn't have to pay the town of Hanover some kind of lost tax revenue?

BIRD: If they did, I've forgotten it.

DAILY: Okay. A couple of things you're credited with as president is really kind of growing the clinic, particularly in southern New Hampshire with the offices down in Concord and Nashua and Manchester. What brought that about, as the entire clinic, and also your motivation to do that?

BIRD: Let me divide that into two. I'm always happy to take credit for anything. The credit I should take is for listening to the genius of the Hitchcock Clinic administrator, John Collins, who is still there and who, during all my time as president and for all the presidents subsequent to that, and a good part of Dick Cardozo's presidency before me, I think, should be credited with most of the original thought and vision which led to much of what's happened to the medical center.

That said, in the 1980s the practice of medicine was changing. And one of the ways in which it was most obvious was the advent of HMOs and managed care. We had no experience with that in Hanover, nor did we most likely have a population base which was going to give us that kind of experience. Further, we had ambition to develop a medical center which was a regional center. And thirdly, to some extent – I think some of us felt it more than others – there was an opportunity for Dartmouth to become part of the state of New Hampshire, which, in

most ways, in my opinion, it hadn't. It existed here in splendid isolation.

An opportunity sort of fell into our lap. We had talked about trying to export the model of group practice because we felt it lent itself to managed care and to HMOs, or whatever was going to come from that. But except for the Concord clinic and the Keene clinic, there weren't any other examples of it in existence. We felt we had a product, if you will, of a way of practicing medicine which was good, which was worthwhile for patients and people benefited from it. And we felt that if we could persuade people to accept us for the value system, that maybe we could make this happen.

Well, we were approached by a pediatrician, a graduate of the Dartmouth training programs, name of Gene LaRiviere [Eugene W. LaRiviere DMS '63]. Gene LaRiviere was a native son of Manchester, New Hampshire, grew up in a blue collar family, and is one of those people who is not only a wonderful pediatrician but has dedicated himself to giving back to the city of Manchester many-fold. Gene saw what we had here and said there must be some way for us to start a clinic in Manchester. We said, "Great idea, Gene, but no, because we have no money and we have no endowment, no seed money, nothing to start something like that."

At the time, there was a managed care practice in Nashua called the Matthew Thornton Health Plan. The Matthew Thornton had been started by a New Hampshire physician named Jim Squires [James W. Squires]. Jim was raised in New London, where his dad was on the faculty and his father-in-law was president of the college, loved the state. Jim had come back from Massachusetts as a surgeon and really didn't have any interest in managed care or HMOs, but he wanted a prepaid medical practice where people could just come into his office and he could do whatever he needed to do for them, and the money was out there, and he had enough to live on, and that's what he wanted. Well, of course, the only way you could really do that was in sort of a managed care practice.

It caused outrage with the New Hampshire Medical Society. They knew he had to be a communist. (Laughter) As he was sort of boycotted, he was struggling and this is retrospective, this goes back into the '70s, way back in the early '70s. Some of us thought he was doing a decent thing, so we quietly allowed some of our residents to go down and, on

nights and weekends, help Jim. He wouldn't have been able to keep the doors open otherwise.

There was an old friendship that went way back between Jim Squires and Dick Cardozo and myself. Just about the time that we're talking about, Gene LaRiviere in the '70s – actually, it was very early '80s – saying, "Can't we do something in Manchester?" Jim called me one day and said, "Harvard Health Plan has its eye on us." And he said, "I'm stuck. I can't grow this plan anymore, and it's the wrong size. We're having financial problems. We've either got to be something bigger or be absorbed." I said, "Okay. What are you thinking of?" He said, "I don't think you can handle this from Hitchcock, but I just don't like the idea of medical care for New Hampshire being controlled in Boston." I said, "Well, we double-dislike that."

So Dick Cardozo and I went with a fellow named Phil Schroder [G. Philip Schroder] who was one of our administrators in the clinic, and John Collins, and we sat with Jim Squires and we talked and talked. Then we said, "How about if we started a small Hitchcock Clinic in Manchester. We could probably make it work if you would provide the patients, because you have insured people, if you named our docs as the ones that would be the ones available to them." So that's how we started.

We went to John Stabile, who was a New Hampshire state senator and real estate entrepreneur. He was building a condominium office park in Manchester near Bedford Commons, and we got him on a handshake, really, to revise one of the buildings to make it a doctors' office building. And with nothing more than hope and belief that it was the right thing, and the trust from Jim that patients would show up, we opened up with two pediatricians and three internists. There was a group of three internists who were also interested in trying this.

DAILY: Were they all folks who were up here?

BIRD: No. No. We were of a belief that to make this work we had to find physicians in the community who thought we were doing something right and wanted to join us. We never bought a practice, we never paid a penny for them. They had to want to do this because they liked the idea. We also had things to offer them. Our benefit plan of retirement and health benefits was attractive, and disability, things of that sort.

So it started with five docs. Then that kept growing and growing. That led then to discussion of maybe we should take over the Matthew Thornton, and we spent most of a winter meeting at night so no one would see us all together, because it was going to be a sensitive issue, for many reasons. But Harvard Health Plan was beating on the door to buy the Nashua practice. Well, Jim, to his everlasting credit, said, "No, we're going to go with Hitchcock."

So we became the owners of the Matthew Thornton. We had little or no experience with how to run a managed care practice. We learned a lot in a hurry. We got beat up in the process on occasion. But from that, we now had a large clinic in Nashua of physicians who had never worked – most of them young physicians – never worked for anything but an HMO and didn't have a clue what a multi-specialty group practice culture should be. That was a big struggle to bring them into the fold and have them work as a group. Believe it or not, while they were all in the same building, the culture was different than the HMOs. People came to work and did their thing and left. Well, we didn't want that. We wanted people sitting around and talking and making one and one equal three.

That led then to an approach from the Concord clinic, who had been in existence for a long time but they were pretty much a bottom line oriented organization. Eventually, Keene clinic later, and in Concord and Manchester we now have our own buildings, and it's grown into a system of hundreds and hundreds of physicians.

It's had its problems. There were times in the HMO industry a few years ago when Matthew Thornton... The amount of money for the premiums wasn't enough to pay for this thing, and the southern region, as we call it, was losing money. Folks here in the mother campus, if you will, were saying, "Gee, are we paying for all of this on our backs?" Well, in a way, yes. But also, they were also the beneficiaries of now a statewide system of referrals, of patients coming here, and of the Dartmouth name being a statewide valuable resource for people in New Hampshire. The cancer center benefited from it. Everybody benefited from it.

The Matthew Thornton was sold, as you know, eventually, to Blue Cross Blue Shield of New Hampshire, and I'm happy to say that some of the money from that – some millions of dollars – is now in a fund which is being used by the medical center to promote group practice and primary care medicine and women's and children's issues.

It was quite a ride for a while. I lived in a car for the last three years I was president and would go from one fire to another. But there was tremendous energy, enthusiasm, and always this idea that we're doing something different and, to a degree, controlling our own destinies more than a lot of other physicians were.

So that's, in a sort of a rambling fashion, how it all began. The only credit I can take is maybe some ability as a salesman to – because I became totally convinced it was right, but the pieces that needed to come together were far outside my talents. People like John Collins and Kevin Stone [Kevin C. Stone TU '84] and Greg Banks [P. Gregory "Greg" Banks] and the clinic administration, who worked night and day to pull all these agreements together and arrangements. Our attorney, successor to Bob Reno, a man by the name of Neil Castaldo [Neil F. Castaldo '66], shortest Dartmouth basketball captain ever, he tells me. Neil has been just a godsend.

But all of those folks were able to buck me up and help me to express what I knew was the right thing. It's kind of funny in medicine – I'm not sure it's anything to be proud of – but you can get a group of doctors in a room and have an administrator tell them something, and they'll sit there stone-faced. Then have another doctor come in and tell them exactly the same thing, "Oh, yes, I agree with that." It's an ego thing, I guess. But you've got to have a doc in the mix somewhere who believes in it but who has clinical credibility, and that's back to my earlier comment. You can't sit in an office and do this. You've got to get your scrub suit on and still be in the operating room so that you're credible.

DAILY: That's wonderful, the idea that the clinic carried the Dartmouth name out. There's something funny about that, too, when you think about it. Is there anything else you want to mention about the move of the clinic down state?

BIRD: I don't think so, other than it's even broader now, and there are some smaller group practices. We've even infiltrated into Vermont, much to the displeasure of some of the Vermont leadership. But we were filling vacuums. Gifford Hospital, which I was particularly involved with, and Randolph was going under. We brought a sort of an eclectic group, an ophthalmologist, a wonderful chap who's still there, and an orthopedic surgeon, and helped with a few other recruitments. And that hospital has flourished and has done well. So there've been a lot of little

success stories. Newport, Vermont, has had some wonderful relationships with Hitchcock. I look at it as one of the most rewarding things that happened to me in my time there, was to see this broader system.

DAILY: On the Dartmouth side of it, was there positive backing to do this?

BIRD: I think there was skepticism, worry, concern over who was really in charge. The department chairs, for a long time, felt that we kept them out of the southern region. And the reason they felt that way is because we did. But we had to. We were really so absorbed in running the business aspects of it and convincing the physicians to gain confidence in themselves that to bring in an academic component right away would have been just overwhelming. On the other hand, part of what we had to offer people in the southern region was, if they were interested in being a teaching resource, that faculty appointments – on a fairly junior level but faculty appointments – the opportunity to have medical students and residents coming into their practice, all that could take place and that they could have a relationship with Dartmouth Hitchcock in Lebanon.

We knew that we needed the department chairs, but the whole thing didn't go in a series of nice steps. It was sort of a lurch from place to place to get it done. So for those reasons, "What are you doing down there?" I think was probably the question most of them would ask or want to ask me at board meetings. "What are you up to? What's going on? We hear all these things, but we don't feel as we're a part of it." I think, in fairness, we didn't have a way of being inclusive with them. And the normal speed of academic decision-making would have ruined us. That's all changed over time, and now I think the chairs pick and choose where they want to be involved, and they're comfortable with that.

DAILY: The other major thing you had in that time period would have been the relocation out to Lebanon for the hospital. What issues in particular involved you as clinic president?

BIRD: Trying to prevent it from staying on Maynard Street. (Laughter) The easiest part of this whole process was the move and the new building. The toughest was stopping the battleship that was going thirty knots an hour to keep everything on the Maynard Street campus with additions on Dewey Field and complex parking garages, and everything else. If ever anyone needed evidence that that would have been a disaster,

just look at the expansion that's already taking place at the medical center ten years later, the need for more ambulatory care, the need to rely less and less on keeping people in the hospital, and the need for more space. Whatever would have been built at tremendous cost here would have already... I think the next step would have been to take the golf course, and that might have met with some resistance in certain... Well, we talked about the golf course in Etna and putting the campus there. That talk lasted about twenty minutes. There really would need to be a huge piece of land, and it would forever block the college. I mean, that would have been the end for the college.

So that was the biggest thing. There were many different proposals of how we would build new floors and new additions. I had lived through the addition. When I came to the Hitchcock, the Faulkner building was three stories high, and when it went to the eight-story building was all during the time that I was practicing in that building. You haven't lived until you've tried to conduct a surgical and anesthesiology practice when the building's being rebuilt around you and floors are being put on top – it was a nightmare for two years, or three years. And to multiply that many times from what they were talking about. Plus, we were in an old facility. Parts of that facility, no matter how strongly they had been built, were approaching a hundred years old.

There was just reason after reason and deep down, even the proponents knew it, but it was the pressure from the basic science medical school and group to not separate the conjoined twins. "We gotta keep everybody here. There's some sort of nurture that goes on by being physically..." And we never saw those guys anyway. The parking lot's a big place, and you can go just as easily on your bike or in a car from one end to the other. But many people didn't want to believe that could be and that this separation was going to destroy the medical school. Well, it hasn't happened. Thank God it hasn't happened.

DAILY: Any other things that you had to deal with, with the whole relocation once it was decided to go forward?

BIRD: Yes. But they were mostly technical things. We soon realized that as much money as we were going to spend, we wished we'd had more. We made some compromises, one of which I am reminded of every time I go and see my internist or my ophthalmologist because they shake their finger in my face and say, "If it wasn't for you, we could both turn around in this office at the same time." I was the one who

made the final decision for the clinic space to cut one foot off the length and width of each exam room, because we were desperate to build more examination rooms in order to have extra rooms for students and house offices. They all said, "Well, you'll never have to practice in one. You work in an operating room." But those exam rooms are a little too small, and it's very crowded in there. And they blame that on me.

The biggest problem was getting the decision to go there. Once that was made, everything fell into place.

DAILY: During your presidency, what would you count as your major accomplishments, and then perhaps the things that you wanted to do that you didn't get to do?

BIRD: I think the first thing was helping to create the public board of the new clinic and bringing the clinical faculty, the practice group, back to the table where the negotiations and the decisions were really being made. Second would be convincing some of my colleagues that it was right for us to be an academic medical center and to take on the accountability to the academic process. Not totally but at least more than they had to the department chairs and that they really had to be at the appropriate place in our scheme.

We've touched on the others. The development of the southern region. I still get a great feeling every time I drive through Concord or Manchester to see those buildings and know that we started basically – we started in the storefronts. The first time we added space in Manchester after the original opening was in a shopping mall. It's all we could afford. They converted it, and it looked pretty nice, actually. But from that to the buildings which were dedicated buildings. I think those are probably the accomplishments that I have the best feeling about.

And also restoring the – in addition to getting to the table with the other institutions – a level of colleagues. I enjoyed a good friendship with David McLaughlin. He was controversial as president and had his own way of doing things, and he was often difficult. But I still see him, not on a regular basis, but we still get to see the McLaughlins once in a while. He made some real contributions during his presidency. They're different, as each president is. But getting to restore a level of credibility with Parkhurst was important.

And that carried over with Jim Freedman [James O. "Jim" Freedman]. We didn't have enough books for Jim to be happy. We did too much with our hands. Jim brought a different view of it to the table.

Those are some of the things, I think, that I look back on with the most happiness. And I'd have to add also seeing my daughter [Suzanne A. Bird DMS '85] graduate from Dartmouth Medical School.

DAILY: What year did she graduate?

BIRD: Nineteen eighty-five.

DAILY: So right at the beginning. Did she go to Dartmouth as an undergrad?

BIRD: She went to Amherst and then came back here to do her medical school. She now teaches at Harvard. She's a psychiatrist and does emergency room psychiatry there.

DAILY: What led you to accept the position as head of the Department of Health and Human Services here in New Hampshire?

BIRD: Timing is everything. In 1990 I knew that we were headed for a period of change again in the clinic where whoever had my job, at some level, needed to promise themselves to be there for five years or more. Although I had only been president a little over seven years, it had been a pretty intense time. During the time I was doing that, I was also president of the American Board of Anesthesiology, which was – I was kind of burned out a little bit. Perhaps most telling to me was my clinical commitment was down –

**[End of Tape 2, Side B – Beginning of Tape 3, Side A]**

BIRD: Some days I was having to cancel my one day. As I mentioned earlier, I really believed that the credibility of the clinic president required a clinical presence. Steve Plume [Stephen K. "Steve" Plume] carried that on and continued to do cardiac surgery, and Tom Colacchio [Thomas A. "Tom" Colacchio], who is now president of the clinic, is an active general surgeon in addition to everything else he does.

Well, I saw that I was on a collision course between my principles and my behavior. I got a call one day from a fellow named Pat Oliver, who was the chief administrative assistant to then Governor Judd Gregg. I had known Judd for a number of years when he was in Congress. Not

well, but I knew him pretty well and occasionally talked to him about medical things. They asked me if I would come down and talk with them because they wanted to get my input into picking a new Health and Human Services commissioner. They had a holdover person from the previous administration. So we talked for a while, and I gave them my views. They asked me if I could come up with some names. It's not a position that requires a physician. It's helpful, I think, in some ways. Health and Human Services in New Hampshire covers half the state's budget and all of the programs of aid to the children, youth, elderly adult, the welfare programs, public health is all in one department. I promised that I'd try and come up with some names for them.

The next day, Judd called and said, "Do you have any names yet?" I said, "Well, not really." He said, "Why don't you do it?" I said, "Oh, come on." He said, "I'm serious." He said, "You always have said you'd like to do something in public service." And I said, "Yeah, but I've got a job here." Then it suddenly dawned on me, this was a way for me to maybe change careers and do maybe a little favor for the state and a big favor for the clinic by stepping down before someone decided they should push me out. I thought about it for about a week and talked with Carolyn and drove to Rutland to see Ray Keyser, my mentor, and decided that I would do it.

So I sort of fairly rapidly made the transition. It wasn't something you could leave hanging too long. That was four great years. I loved it. One term was enough, though. And the university system was – it's been fun to transition from medical practice through two more careers and has just made retirement very easy.

DAILY: I was curious. How did you end up in the university system?

BIRD: Well, that's funny as well, because that board of trustees is appointed by governor and council, and before I became commissioner, Ray Burton, who is the executive councilor for District 1, is always pushing to have north country people on state boards and agencies. He had an opportunity to choose a nominee – it was then Governor Sununu – because a north country trustee had stepped down. So Ray called and asked me if I would be willing to serve on the board. I said sure, so I did. I served a total of ten years on that board.

While I was on that board and in Concord, I spent a fair amount of time chatting with the governor. That was when New Hampshire was in a

financial crisis, and we were generating the Medicaid money from my department to solve the state's budget problems, \$860 million worth. But while we were doing that, we were also talking about the university system, which was one of Judd's favorite targets in terms of taking money away. As he was going to Washington, he said, "You know, I'll be able to help the university now that I'm in Washington." And I said, "Every penny of that's going to be conscience money, Gregg. You owe it." And he has been incredibly generous to the state system.

But that led to the board asking me to chair it, so I chaired it for four years. That was an experience. It's when you're not an applicant, you're a supplicant, and you just keep going to the legislature trying to persuade them that investing in educating their population is the right thing to do. It's been a slow struggle.

DAILY: You're certainly making serious contributions to New Hampshire from a platform here in Hanover.

BIRD: It's been a wonderful opportunity for me. I've loved every minute of it. Our son went to the University of New Hampshire and flourished there, and we feel a lot of gratitude to that. Public higher education has always taken such a knock in this state, and it's really wonderful. The university system, particularly the campus in Durham, is just so wonderful.

DAILY: Are there any other things you want to talk about in terms of your career?

BIRD: I don't think so. I'm happily enjoying Florida in the winter and Hanover here in the summer. Spent six years with John Hennessey on the board of Kendal, which was a great experience. That's a wonderful organization up there. I still view Hanover as home and always will. But, no, it's been a great time. I can't imagine doing my life over any other way. Group practice and the Hitchcock has been just... It always has given me much more than I ever gave it.

DAILY: Well, thank you.

BIRD: Thank you.

**End of Interview**