**Please Note**

**This oral history transcript has been divided into two parts. The first part documents the presidencies of John G. Kemeny and David McLaughlin and is open to the public. The second portion relating to the presidency of James Freedman will be open in 2023, which marks twenty-five years following the end of his administration.**

**This is part one.**

# Dr. Robert W. McCollum

## Dean of the Medical School, Emeritus
## Professor of Community and Family Medicine, Emeritus

An Interview Conducted by

Daniel Daily

Hanover, New Hampshire

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Hanover, New Hampshire

INTERVIEWEE: Dr. Robert McCollum

INTERVIEWER: Daniel Daily

PLACE: Hanover, New Hampshire

DATE: June 19, 2002

DAILY: Today is June 19, 2002 and I am speaking with Dr. Robert McCollum, former dean of the medical school from 1982 to 1990. Dr. McCollum, the question I would like to start out with is what attracted you to medicine early on?

McCOLLUM: That's an extremely complicated question…a simple question with a complicated answer. I guess, like a lot of kids in that time frame which was in the early '30s, I saw medicine as being sort of the ultimate. Part of that was a rather severe illness of my mother, which brought me personally into contact with the family physician over a long period of time because those were the days of house calls and he was a visitor every morning and every afternoon at the end of his day and he became sort of a hero figure to me.

Then, subsequently, my sister married a physician who is an orthopedic surgeon and I had become very close to my sister as sort of a second mother during this period of time. He was another person that I knew well, I admired and sort of led me into medicine. So that from the mid-l930s on, that was my goal.

I have to say that then I found I was interested in science in high school and, in college, I pursued a double major in zoology and chemistry, leading to pre-med requirements that were met and, lo and behold, World War II came along right at that point and it was, I have to say, in a way a convenience to have a medical goal -- a medical education goal -- because that was one of those goals that allowed deferment from the draft. So that was my entry into medicine and medical school. It was as simple as that.

DAILY: Now you were at Johns Hopkins during the war, right?

McCOLLUM: Well, I went to medical school at Johns Hopkins under the encouragement of my mentor in college who had received her Ph.D. at Hopkins and who felt that I shouldn't strive for less than that and encouraged me to apply. I had no feeling of being admitted at all and suddenly I found out I was, so that's the way I ended up there. Otherwise, I probably would never have gone to Hopkins in the first instance.

DAILY: Now in terms of what was shaping medical education at that time, particularly at Johns Hopkins, what kind of… Looking back, what were some of the factors?

McCOLLUM: Well, I think the main thing I realized, having visited several medical schools in the process of application… Although during World War II, you didn't travel quite as easily as kids do now who are running around all over the country visiting medical schools, so that my visits were largely limited to those in the Texas region or in the south anyway, including Tulane. I did have a brief visit at Hopkins prior to my application and I was overwhelmed by the size of the institution and by the complexity of it and I think by the academic structure there, which was quite different than the schools in Texas, which were struggling, I think during that time, to develop an academic identity in an academic place but had really very little in the way of research interest. That was probably the thing that really made me feel that's where I wanted to go…not just the name, but the character of it. So that was really the drawing card.

DAILY: So the emphasis on research at Hopkins appealed to you?

MCCOLLUM: It did, and also being in a different part of the country. It was totally different. I think I found it a fascinating thought. I had originally thought I would probably go away to college somewhere, but I ended up going to Baylor because that was close at hand. I was sixteen and war was on the horizon and my parents were not very interested in my going away from home at that point. I really felt I wanted to get on with it, so I did.

DAILY: What led you to go into epidemiology?

MCCOLLUM: Epidemiology. Well, that also brings in a family thing in a sense. My brother-in-law was an orthopedic surgeon in Dallas and did a lot of pro bono work at Scottish Rite Crippled Children's Hospital in Dallas. So during the summer between my second and third year in medical school, he wanted me to work with him in an externship -- or what we then called an externship -- at Scottish Rite because he was hoping I would go into orthopedics as well. When I found myself there that summer though, we were beset with orthopedic procedures trying to correct problems that had arisen from acute poliomyelitis which was rampant.

That same summer, there was a major epidemic of polio in Dallas and I found myself across the street working in Parkland Hospital [Parkland Memorial Hospital (Dallas, Texas)] theoretically to help out, although I don't think I was of much help to anyone, where respirators were lining the hallways with acute polio patients and where there were efforts at ameliorating the muscle spasm using what then was the Sister Elizabeth Kenney technique of hot packs. So that, without air conditioning, and you remember this was Dallas in the summer of '46, there was no air conditioning in any hospital in any place except the operating rooms and some of those were not air-conditioned. So add that to the multitude of machinery going and the hot packs being applied and it was a pretty desperate situation.

I guess that I would have to say that convinced me, without really realizing the level of it, that prevention of a disease was far more desirable than trying to do something about it once it had happened. It was at about that same time that polio virus was first isolated in the laboratories and worked with as an experimental infection in animals, particularly Rhesus monkeys. So, although I didn't have that in mind that summer at all, I was soon to become more aware of it than I had been. That really sort of set the stage that I wanted to think of ways in medicine that could be preventive medicine, rather than curative or whatever…certainly not surgical correction of deformities.

Then a few years later, my father had surgery and this was in the early days, really, of transfusion availability on call. In other words, post-World War II, preservation of blood for a prolonged period in a refrigerator with proper anti-coagulants

and so forth. That was the first time that was a reality and you could have a bottle of blood waiting in the operating room in case you needed it or have more backup somewhere. I subsequently found out that such was the case with his surgery that the bottle of blood was there and, without the necessity of using it, the surgeon said, "We've got it. Use it." So they did. He subsequently developed serum hepatitis about three or four months after his surgery.

This is a very complicated way of getting to say that, then when I got to Yale for my residency in internal medicine, I had the opportunity to work with Dr. Gerald Klatskin, who was the leading hepatologist or one of the leading ones in the country at that point. He was developing techniques for liver biopsies that had not been widely used before and all of his patients essentially got liver biopsies. At the same time, I was waiting to be called for Korea. While waiting, he suggested that I might contact Dr. John Paul, who was the head of preventive medicine at Yale and who, during World War II, had led the hepatitis studies for the military.

Dr. Paul was right across the street in the laboratories and working in the field in epidemiology. He suggested that I work with him the following year while I waited for my call. So I started working with hepatitis in the laboratory and doing some field work in hepatitis as well under his guidance.

Another person working with Dr. Paul very closely at that time was Dr. Dorothy M. Horstmann and she happened at that point to be in Tahiti working on a polio epidemic. When she got back, I was fascinated not only with the research she was doing, but the fact that she got to travel and do fantastic things in the process of it. You couldn't even fly to Tahiti at that point. She had to take a ship, so it was even more enticing.

I still hadn't been called in the middle of the year when Dr. Paul called me in and said that the situation in Korea was bad because epidemic hemorrhagic fever that winter or that year had been a real problem and the Army wanted to send materials over. We had chimpanzees as well as monkeys in the laboratory. I had been using the chimps for hepatitis work and he wanted me to try hemorrhagic fever materials in the chimps. That led me then to a relationship with Walter

Reed Army Institute of Research and with Dr. Joseph Smadel, who was the head of the [inaudible] disease area there.

The threads keep getting mixed up but Dr. Horstmann then said that she had need for some help with polio work, so that summer I went out to Ohio where in Wooster, Ohio, there was a polio epidemic involving a lot of the Amish people. She had been concerned with the role that viremia might play, having studied it in monkeys, from infection by the gastro–intestinal route; but, the virus getting into the central nervous system, it had to go by way of the blood. So, if you could find that route was really essential and you could block it in some way appropriately with antibodies or whatnot, this would be a major way to interrupt the process and particularly where you had families where the transmission was probably from the first infection to other members of the family, you could get in in time to do something. That was the logic behind it. So I went out and bled members of the families of cases and frequently in their homes on the kitchen table. We were able to demonstrate viremia in a small number admittedly, but it proved that this was a likely route and a point at which an interruption might take place.

That same summer, Dr. William McDermott Hammond, working out of Pittsburgh, was testing out gamma globulin as a prophylactic measure, working largely, I think, in Utah. That was another way then that you might use the preventive aspect of antibodies if you get them in at the right time. Otherwise, his plan was to go into an epidemic area and give everyone gamma globulin because we knew that it contained antibodies to the polio virus.

DAILY: Did he end up doing that in any instance?

McCOLLUM: Well, it turned out that it was not an extremely practical matter because, getting that amount of gamma globulin, getting it into the right place at the right time and being effective for any reasonable number of people, it was just hard to do. So that approach, while it still was alive for a few years, was interrupted by the presence of Jonas Salk, who was also working out of the same general area, who came along with his vaccine, having worked out the technique with influenza viruses earlier and then, right behind him, Albert B.

Sabin, with his oral vaccine, polio vaccine. That gets a little bit further along in the history of things; but that was. My part in polio was very limited and it was right at the beginning of that. I maintained the interest and I got to know all the people involved because I stayed in communication by way of Dr. Paul and Dr. Horstmann.

But my hepatitis interest continued until I went to active duty and was sent to Korea to a special MASH hospital, which was set up for doing research. I had established the sort of technical and practical laboratory approaches to trying to isolate the virus or whatever the agent was and we assume it was a virus that was causing epidemic hemorrhagic fever. That was maintained and, when I left Korea and went to Japan to the 406 Army laboratory there and set up to use materials that I had collected in Korea or to use new ones that were coming in. We were getting less and less hemorrhagic fever because the combat had stopped at that point and the movement of troops had changed, the exposures had changed and hemorrhagic fever had not dried up completely, but there was no point in keeping a laboratory going there. So that was my introduction to epidemiology and to research, really. It was through a series of connections that were unpredictable and happened to coincide with my availability and my interests and with people that I really admired and enjoyed working with. That's a long answer to a short question.

DAILY: No. That's a great answer. You mentioned doing fieldwork. What did that entail for you in the different situations like in Wooster and in Korea?

McCOLLUM: Well, in Ohio, it meant getting notification every day of all the cases that had been brought into Akron. Most of them were taken to the Akron hospital because there were no adequate facilities in the periphery. Wayne, Lodi, Medina, Wooster were all areas where there were cases and the moment a case was reported, somebody got in touch with me.

This was largely through the intervention of a man who was head of the March of Dimes for that area and who…the March of Dimes sponsored a good part of the polio research. It then became The National Foundation. Once I got the name and identity or the location of the case, I would get in

touch with the family and try to talk my way into the family's home to bleed the other children and the parents and get a history. That was probably easier than most people would think because everybody was so frightened about polio at that point that anything you did, even bleeding a child on the kitchen table…that was not one of my favorite avenues of approach…but it had to be in many cases. That was a type of field study or epidemiological approach that was fairly unique to a situation that doesn't exist with a lot of others. You go in after the fact.

That was quite different than Korea where I never went out into the field to catch somebody because the cases of hemorrhagic fever, when they were suspected or diagnosed in the combat area, were helicoptered into our hospital. So the patients came in and you had no access to their comrades or whatnot because you didn't go out to bleed in the field. I never got subjected to enemy fire trying to get a blood specimen. [Laughter] So they were two totally different situations. There are many others…there are no two that are exactly alike.

DAILY: It sounds like you had the opportunity to work with a lot of people who were really pushing on some of these issues.

MCCULLOM: You know, you look back now…I'm talking about fifty years ago…these people were dedicated scientists and they were dedicated humanitarians. Some of them may have been looking for a Nobel Prize, but they were noble people. They were just wonderful.

I really got to know Albert B. Sabin extremely well. He took up an interest in hepatitis…had had one…an interest in it for a long time. He didn't personally work with it very much, but had a lot of wise thought and suggestion and helpfulness. Salk [Jonas Salk] less so. He was on his own thing and I think he probably went to his grave disappointed that he didn't get the Nobel Prize for his work. Sabin probably thought that, but he got so many honors all over the world that that would have been a minor capstone to the whole thing.

People like John Paul and Dorothy Horstmann and [Joseph L.] Joe Melnick, who died at the same time Dorothy did last

January -- both with Alzheimer's -- were mentors that were absolutely fantastic people and so many others, names that don't mean anything to anybody else perhaps but me and a lot of people who are long gone now. But science was different then and the individuals, I think, in many instances weren't driven so much to having four hundred publications to put on a CV, but were intensely concerned with working themselves with the subject and trying to make a contribution, rather than trying to train another twenty individuals who would put their names on papers. That's being very blunt, but that's what a lot… You know, I read in a recent article in *The New York Times* that was derived from one in *The New England Journal* about how people plaster their names onto papers that they have had little or nothing to do with and it sometimes catches them by the tail and swings them because they find that they have put their name on something that they really didn't know anything about and it has had to be withdrawn. I have had a couple of friends who have suffered that fate, so, you know, things were different.

DAILY: You stayed on at Yale. How did that come about?

McCOLLUM: Thirty-one years. [Laughter] Well, there are a lot of things about that. One, it was a wonderful place to be. It combined all of those things that, in the beginning, were just sort of perfect. The location was great. The faculty members were all great. It was small. We only had sixty-five students in a class then and there was a certain capacity there for being able to pick up the phone and call anybody and know who you were talking to on the other end. Yet it was a vital, lively place with change all the time, too. People you could not only know, but respect for their work and as friends.

I liked it. I got married there. Had family there and it didn't seem to me that there was any need whatsoever to ever leave it as long as things worked. Fortunately, just as with other things I have talked about, everything seemed to fall into place from one to the next to the next to the next along the line and I never felt insecure about whether I would be reappointed or would be promoted or whatever and never knew what my next interest might be. So thirty-one years was a long time, but a short time.

DAILY: Looking back on your years at Yale, what do you think…your different experiences at Yale…what do you think prepared you there to come to the deanship up here at Dartmouth?

McCOLLUM: Well, I guess the first thing that prepared me was an increasing responsibility in the department that I ended up in, which was a separation from the department of internal medicine. It had a section of preventive medicine that was headed by John Paul. When he retired, I had a joint appointment with the department of public health to teach epidemiology in their master of public health program. That was in part trying to bridge between what, in essence, was a school of public health contained within the medical school administratively and structurally and a department in the medical school that had a relationship with the school of public health, but didn't have a responsibility. So John Paul sort of engineered this relationship by having me adopted by the department of public health.

I found there…The chairman of the department was Ira [V.] Hiscock and we worked very well together and when the time for his retirement and John Paul's came up (at more or less the same time), the medical school and university made the decision to create a new department incorporating public health and preventive medicine to become the department of epidemiology and public health. It would still maintain its accreditation as a school of public health and would offer degrees at the master's level and at the Ph.D. level.

As the Ph.D. programs there came under the graduate school at Yale, it sort of made a triangular relationship that they hoped would work profitably, both academically and in research. I was the only person who had a foot in each camp, so to speak. When that decision was made, they began looking for a chairman. The person that they ended up getting was someone who came from the World Health Organization, Tony, Anthony Monk-Mason Payne, with a hyphenated middle name, who was British but who had been the chief of the endemoepidemic disease section of the World Health Organization for a number of years. Tony Payne came over in 1960, I guess, and he and I saw things so much in the same way, he sort of took me in as a partner as he had to take over in a new setting…a transition from an old formulation of academic and research and administrative

things into a new form. Because I had been there for a long time, I had reasonably good relationships with people on all sides and, as the new guy on the block…even though he was a little older than I…we hit it off immediately.

So, without any official designation, I sort of became a vice-chairman or something or other and never had any identity on the books or in print. That was the way that I wanted it because, once you are in something like that, you are trapped I think. [Laughter] So you want to avoid titles if you can and work subsequently. That, by the way, later on came to be a downfall, but that's…

When Tony decided to go back to WHO [World Health Organization] in '66, Kingman Brewster was the president at Yale and I had conversations with him and Vernon [W.] Lippard, who was the dean of the medical school at the time. Actually, I think Fritz Redlich [Frederick "Fritz" Redlich] at that point had become dean.

Anyway, it was suggested that I might act on an interim basis as chairman of the department and I said, in a sense, "Thanks, but no thanks." It wasn't certain whether Tony would come back. He had actually just taken a leave of absence, but it was pretty certain that he wasn't going to come back. I was in the midst of research and teaching and so forth that I didn't want to disrupt.

Two years later, after he hadn't come back and decided not to come back, they had a search for a new chair and selected a physician from Chicago whose interest was in chronic disease epidemiology. When he came, it was in the midst of the social upheaval of the '60s, the end of the '60s. He was attacked by the community because he wanted to be in a good relationship with the community to develop programs in the community and he was literally taken alive by minority leaders who wanted a lot of things that he couldn't give but, for some reason felt that he had to promise. He had other difficulties and, before his first year was up, I got a call from the dean of the medical school, who was Fritz Redlich at that time, on a Sunday evening asking me if I could be acting chairman for six weeks. [Laughter] As you might guess, the six weeks turned into six months

and it turned out -- something that I didn't really know before, I guess -- that the search committee which had been…

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**Begin Tape 1, Side B**

McCOLLUM: …had considered that I should be asked when they made this external selection. So they didn't go back…the committee came back to meet once and then they called me for an interview. When I went for the interview, it turned out they wanted me to take over. The dean was behind this.

So I became chairman, not just "acting" and suddenly found myself more involved in the administrative headaches as well as the joys because I found that I really did enjoy working with people -- even those that didn't share my thoughts or ideas or whatnot -- and with a department that was in trouble at that point and was even in trouble with its accreditation. So my research started taking a somewhat secondary position in my life.

So, for thirteen years, I served as chairman of the department and can say without taking too much of the credit that we survived our difficult period. We grew and I think we became stronger in academic and in research through a number of fortuitous developments as well as anything that I did actively in trying to plot the course, so to speak.

You know, you take advantage of things that happen that you didn't have any control over that at first appear to be an obstacle or a threat or whatever else and find you can turn it or that it turns itself into an opportunity, rather than a difficulty. So it was largely through that that we ended up being a bigger and better and more respected, I think, institution externally as a school of public health and internally in being accepted by clinical departments and basic science departments who had little or no respect for epidemiology or public health.

DAILY: Okay. I was just going to ask…what were some of the difficulties in the department there in the 1970s at Yale? There…talking about Dartmouth…I am interested in seeing kind of what you had to work through.

McCOLLUM: Well, we had financial difficulties. When you have very little control over your own budget, but it has to go through the dean of the medical school, who is more concerned with other departments in the medical school, who work more closely together. For example, all the clinical departments are inter-dependent and more and more at that period of time, the basic science departments were becoming less identifiable in terms of their own specific prior academic identity. For example, physiology became much more biochemical than it had ever before. It was largely an organ-oriented functional subject and then suddenly, changes or developments in biochemistry not only changed the course of biochemistry as it had been in research and in teaching, but it influenced pharmacology, physiology and then anatomy became an anachronism almost because no one really quite understood why it was so essential that anatomy had to be taught as an independent subject, free of any association or identity with any of the things that you had to use it for subsequently.

So at Yale, the decision to do away with anatomy as an independent department and make it a part of surgery, where the anatomy had its most critical application, which everybody took exception to, in a sense, because it was breaking new ground and how could you possibly get accreditation for a medical school that didn't have a department of anatomy? So the anatomists were fighting for their identity, their independence and their persistence.

So that sort of thing was going on within the medical school at the same time that, in those clinical departments in particular, there were…Its people were insistent on having a department of ophthalmology, a department of orthopedics, a department of dermatology, a department…Every little specialty, sub-specialty, wanted to split out and become a department.

So there was growth, but the growth had to be nurtured by independence and association with others who shared your common need or area of interest. This was happening in the basic sciences as well…neurosciences. They crossed over from physiology to pharmacology to biochemistry to everything else. So there was a restructuring of medical education from the academic standpoint and from the

research standpoint which influenced the delivery of medicine and in the clinical side as well because you don't have a department of x, y or z that is just identified academically or in research interests. If they have a clinical responsibility or obligation, then they want independence there as well, but they have to work within a framework of other departments.

So they…I am using this as an example because that is what I saw going on in the medical school side and I was heading a department that had its own identity as a school of public health, which couldn't have meant less to anybody in clinical or basic science…"What is this anomaly doing in our midst? What right does it have?" Fritz Redlich who was the dean at the time, was not only beset with things that were going on in the community that were difficult for the medical school to deal with, but he had internally difficulties as well.

I have to give him credit and thanks for the fact that he recognized in his own attempt to restructure the medical school by appointing three of us as a dean's cabinet…not as associate deans but one from basic sciences, one from clinical and one, myself, from epidemiology and public health, to work with him as a cabinet, so to speak, to work on problems of the medical school in toto rather than in our own individual areas of interest.

I guess that was really the point at which I realized that you have to work institutionally with attempts to bring all the different points of view and responsibilities and programs into some sort of unity if you are going to have peace in the family, which you don't have necessarily anyway, but at least you would have enough in the institution that it can nurture all of the areas. We were changing also in public health at that point to sub-specialization again.

We were fortunate at Yale in being able to get the Rockefeller virus laboratories from New York moved to Yale to become part of our department. This was financially a tremendous undertaking or help and an undertaking to get people up there. One of those people who came from the New York labs was Max Theiler, who was a Nobel laureate who had rather fortuitously in the late '30s developed yellow fever vaccine which had been an extremely important part of

World War II and he was one of the most benign individuals you can imagine -- South African by origin -- and a wonderful person who had a wit as well as wisdom in equal proportions and was a tremendous help to me in seeing how to incorporate his group. They came up from New York, all as foreigners invading our territory, so to speak, and looked upon as gifts from heaven whereas people who had been in the department for ten or fifteen years said, “What the hell is going on here? They are getting space and support.”

Well, Rockefeller was paying for the whole thing, so it wasn’t costing anybody anything. In fact, Rockefeller laboratories in New York donated a good part of the building that we were in the process of constructing then so that they had space -- an extremely modern laboratory space, animal space and so on for their needs -- which we could use then in sharing. There were a lot of headaches associated with it but, again, it was a matter of building by bringing in something that was valuable that wasn’t going to cost anything financially, but would bring talent and opportunity at essentially no cost and would enhance the department.

So we built internally structures that were more in line with other schools of public health that were independent organizations and having specialty representation enhanced, be it in epidemiology, in virology or in health services administration or in biostatistics. In other words, we managed in all of these instances not necessarily to bring in a force from outside, but to be able to use our own resources then more effectively in building those things that we didn’t have.

So it was a learning experience that went on for a long time. It ended up that we had the department of microbiology, which was another anachronism in the medical school that nobody wanted. It worked perfectly to bring it into the school of epidemiology and public health to join the virology group, which had come up from New York. So that we had parasitology, bacteriology and virology all well represented and epidemiology and infectious disease doing that.

Then Dr. Paul, as his final position in the department, got the World Health Organization to sponsor a serum reference bank and we were one of the ones (there was one also in

Prague and supposedly one in Russia that never really developed very widely) that was a repository for frozen serum specimens collected from populations around the world so that you could have them go into and look to see if AIDS had occurred in that population fifty years ago or whatever. You would have it forever then. We didn't know about AIDS at the time; but when Dr. Paul retired, that had been established as a part of our department as well and was maintained as long as we could get support from WHO and from the CDC which had finally joined in to some degree. That has all disappeared.

So I don't know…That's a long answer again. It was a period of time when there were changes in all aspects of medicine and the other spheres of interest that associate with medicine in medical schools and it was a matter of taking advantage of the shifting tides and trying to find a way of maintaining your own responsibilities in areas, growing, exploring and hopefully coming out positive in the end.

DAILY: So you were really involved very much administratively with all those changes and restructuring. What were you hearing about Dartmouth say in the 1970s while you were in the midst of all this?

McCOLLUM: First of all, I guess I would say that Fritz Redlich was an admirer of Carleton [B. "Carl"] Chapman [AM '68] and, when Fritz was the dean of the medical school and I was part of his "cabinet," we came up to see Carleton one day because Fritz thought Carleton had answers to a lot of questions that he had on his mind.

Yale had just started a physician's associate program, which most people in the medical school I would guess had serious questions about. It was headed in large part or structured in large part and headed by a member of the dean's group, an associate dean. But people were not very comfortable with the concept of a physician's associate and certainly not Yale Medical School sponsoring such a program. It was almost worse than public health. [Laughter] To some people, it was even worse than public health because you bestowed upon these people some clinical responsibility that rightfully belonged to the physician and physician only. You didn't even give it to a nurse because this wasn't a nurse's

program. This was de novo. You came in and it was taking advantage of some of the people who had been in the military service as corpsmen.

DAILY: Was this during Vietnam?

McCOLLUM: Well, this…even from Vietnam. The concept had come from Dartmouth. You know, we had that program and Carleton was the one who had been largely responsible for its Medex. So we came up to see Carleton because of Fritz Redlich's admiration for him and because of the experience Dartmouth was having and had had with this program. It was not being successful. I think that would…I am sure there are others who would take exception to my saying that because here I was here for a day and I had no perspective on it. [Laughter]

I was impressed with Carleton. I was not impressed with Dartmouth Medical School. Having come from Yale where I saw Nathan Smith's portrait practically every day and came here and saw his portrait -- the copy of it here -- and realized that this relationship went far back, but it wasn't Yale.

DAILY: Right.

McCOLLUM: I loved the area up here. We'd come up skiing, mostly in Vermont, not on this side. So it wasn't a lack of familiarity or an expectation that I was going to see some huge medical center arising here; but I had never seen what would become the Dartmouth-Hitchcock Medical Center in its original form. You know, Dana wasn't even finished at that point, if I remember correctly. I have only the vaguest memory of that visit. Quite honestly, I know… It looked rural, it felt rural and that was wonderful, but that didn't strike me as being a medical school of much note.

Now I had had exposure to it even when I was at Hopkins because our class at the third year had two Dartmouth students who transferred because it was only a two-year school here. Then they scattered all over. So I had two Dartmouth classmates in medical school and, you know, I never knew a thing about Dartmouth Medical School from either one of them except that it was very close-knit and they had only about twenty-four students and that it was run essentially by one person. [Laughter]

It struck me when I thought back to it that Nathan Smith was the only professor when they started out and maybe his grandson or somebody was still operating it. [Laughter] This sounds awful to say this now, but my impression of it was…Well, it wasn't negative, it was just that it was a non-impression and I certainly never had the thought that I would ever be here again.

Then forward a long way until our daughter was applying for college in '73, I guess, and one of the places just taking women in was Dartmouth and several other places doing the same thing. So I came up with her for her visit here and, do you know, during that visit, there was never one mention…she was thinking of being a pre-med. There was never one mention of the medical school made in the tour. We didn't see it. I drove over after we had made our visit that day. I said, "I wonder what's happened with the medical school?" So we drove over and it was still there. It hadn't changed very much because this had only been a matter of five or six years I guess. Well, our daughter was not accepted at Dartmouth. She was accepted at Yale, at Princeton, at Brown and two or three other places. [Laughter] So I don't' know what the problem was. Anyway, she wasn't accepted here.

A few years later, our son, who was a ski racer, wanted to come to Dartmouth. I didn't think he had the academic background at that point. He might have had the racing background, so I came here for a visit with him. That was four or five years later and it still hadn't changed very much. There was no mention when we made the tour. He wasn't interested in medicine anyway, but there was no mention made of the medical school at all. I asked about it and the kid who was walking backwards said, "It's up there next to the hospital." [Laughter] That was the extent to which it was recognized by the undergraduates anyway. Then I said, "Do you go there when you get sick?" "Oh, no. We go to Dick's House." I didn't know what Dick's House was. [Laughter] I guess I sort of laughed and said, "Who is Dick?" [Laughter] He said, "I don't know." So that finished that conversation.

So my knowledge of Dartmouth was largely Nathan Smith on a historical basis, two students in my class at medical school

who had transferred, a visit to see Carleton Chapman about a program that the medical school was involved with but we really didn't get into the medical school itself very much as I recall. As a matter of fact, that visit was a quick visit. We drove up one morning, a three-hour drive or better, more than three I think then because we didn't have the full [Interstate] 91. We were here for lunch and for early afternoon and then we turned around and went back. So that's not much of a memory. Then the exposure subsequently on visits here when the medical school got no identity at all. So I didn't know much about it.

DAILY: Okay. So what interested you or who interested you that you should come up here to the deanship then?

McCOLLUM: Well, after thirty-one years at Yale with never any thought of leaving and with kids that…One was in graduate school at the time and one was finishing college. We had an empty nest syndrome at home. We had seen Yale grow to the point that it was so big and I didn't know… Previously I said I knew everybody there and then after thirty years, you suddenly realize that you don't know anybody. You walk the halls, you've got new buildings. You've got new labs. You've got new everything and new people and you are a stranger in your own backyard.

So I guess that was the thing when an inquiry came to me, "Would I be interested?" They were looking for a new dean and quite honestly I think I threw it in the trash or disposed of it anyway. Then I got another letter and a friend on my faculty at Yale said that a friend of his who was on the medical school faculty here had told him that I had been on a list that he had seen. But I hadn't responded and I got this second letter. I think it was after that that I got it. So I wrote back and said, "Well, I'll have a look" or that I would be glad to talk with somebody and I got a call from Ted Harris [Edward Day "Ted" Harris, Jr. '58, DMS '60] who was the chair of the search committee.

This was just before Christmas, I think Christmas of '80 it must have been and we were coming up to Killington skiing over the Christmas/New Year's holiday. So I said I would. If it would be convenient, I would stop over here on our way back. So the next thing I knew he said we had a room

reserved at the Hanover Inn and he would be glad to see me.

We got over to the Hanover Inn late Sunday evening and went into our room and it had flowers in it and everything else. I said, “God, what is…” I didn’t know whether this was routine for the Hanover Inn that everybody came in and found flowers and a fruit bowl or if it was something special. In any event, it was a very nice welcoming and I called him to let him know we were there and he told me that he would like to see me the next morning. Then he said, “Well, could you come over to my house now?” So I went over…he lived right next to the medical school and I walked over from the Inn over there and his wife had food prepared when I got there. We sat down and had a talk.

I had a brief visit the next day. It wasn’t an official one because the committee wasn’t assembled or anything, but I just…and here was the medical school which had changed quite remarkably since my memory of it just seven years before. It seemed to me that it had anyway and I have to admit that my memories are a little vague on that. But in any event, I had a visit.

I got back and my wife and I talked that evening because we stayed for another night and she had been taken around to see Hanover and whatnot by Margaret somebody who was running the administrative side of the committee. We said, “Well, it wouldn’t, you know…Why not explore it a little further and see what it is?”

So I came back for another visit which was sort of an official one subsequently. I knew they were looking for a new president. I didn’t meet John Kemeny [John G. Kemeny '22A] on that visit and I had no idea who the new president was going to be. Then it became more and more a matter of reflecting on this institution at that point in time as Yale had been when I first went there. There were sixty-five students in a class. It was small. Everybody knew everyone else.

It had a major problem and that was that it had a title for an umbrella institution -- the name Dartmouth-Hitchcock Medical Center -- but there was no center. Howard Newman [Howard N. Newman ’56 TU ‘57] had left and Henry A.

Harbury had been appointed as president. I talked with Henry who was very quiet, soft-spoken, easy going. He had been at Yale many years before. I had known him there when he was a junior faculty member in the department of biochemistry. Here he was not only chairman of biochemistry here, but he had established the first bridge between the medical school and the college in having a graduate program in biochemistry that went both sides of the street, so to speak. I thought…This is the way I saw things evolving here possibly…was that the medical school was so closely attached to…not… At Yale, you know, the medical school was still blocks away from the college and they both were institutionally divided physically and otherwise. Though there were programs at Yale that did cross over and, in fact, I had become a part -- before I left Yale -- of the Institution for Social and Policy Studies because we have a lot of things in public health that fit in with that. So I had a joint appointment. It helped me in a sense with not just internal connections at the medical school, but with Yale University as well.

To me this was a microcosm in a sense of a return to the old days that I had liked so much at Yale when it was small and reasonably at peace internally. And here was an institution that was just beginning to evolve. It was going from a three-year program and I have to give Jim Strickler [James C. "Jim" Strickler ’50, DMS ‘51] real credit for having done what he did in establishing the change-over to a four-year and the association with Brown for the combined program because that was intriguing as well to realize that the old plan in which Dartmouth medical students took two years here and then went somewhere else for the clinical years…It built on that and built on the strength of the basic science departments here and the capacity to handle a larger student body and yet not be saddled with a larger student body that the clinical facilities couldn’t handle. I had been on some site visits to other schools when I realized that the capacity to handle the clinical training wasn’t essential to the accreditation that this place…That was going to be its bottleneck if you had had increased numbers of students. We couldn’t anyway without sending them all over the place. This, financially, made a real difference too because the school was in trouble financially in 1980-81. So Jim had done a fantastic job. How he had put this through the works, I never will know I guess.

**End Tape 1, Side B**
**Begin Tape 2, Side A**

McCOLLUM: I had not met John Kemeny in my first two visits and then the announcement was made that a new president had been chosen. I was rather surprised to find out that it was the person who was the chairman of the board of trustees and that his primary background had been in business administration at Toro mowers. You know, that, for some reason struck me as odd. It sort of shook me a little bit in my faith in the institution. I expected there might be some academic person of note because this must have been an attractive place in a search process unless there were problems that I didn't realize existed and it really did sort of take the wind out of my sails on my interest at that point.

I also found that on my next visit here it struck a lot of people that way, but the medical school people didn't seem to be very concerned about it. Nobody over there expressed much concern. Then I guess it wasn't long after that that I got a call from Ted Harris saying, or asking me, "Are you really interested?" I said, "Yeah, I really was interested. I found it fascinating, that I didn't quite understand the choice of a new president, but I really wasn't frightened by it." Maybe what they needed really was a CEO rather than a president of Dartmouth College.

I think it was right after that that I got a call from Dave McLaughlin [David T. "Dave" McLaughlin '54 TU '55] from Minneapolis. I wasn't in at that time the call came, so I called back and he was at home. His wife said, "He is out mowing the lawn." And I thought, "Oh, boy, he is out with his Toro." She assured me that it was. [Laughter] He came to the phone and he was the most delightful person. We had quite a good chat on the phone and, yes, he wanted to meet me and so forth.

A few days later I got a call from him asking if I could meet him in New York at the Yale-Dartmouth Club. [Laughter] Early morning. He said John Kemeny would be there and he was going to be meeting with John Kemeny and, if I could come down, it would be great. So that was my first meeting

with John Kemeny. When I got to, as I call it, “The Yale Club,” but they informed me it was “The Dartmouth Club” for that meeting, I called and John Kemeny answered the phone and said, “Come on up” and gave me the room number. When I knocked on the door and he opened it, the smoke just billowed out. I thought “Oh, my god.” I couldn’t…I was really hesitant to walk into the place. [Laughter] There was Dave McLaughlin sitting in there as well. He had already arrived and they were both smoking. Now this is a real problem to try to go into a situation in which the current president and the future president are both smokers. But, be that as it may, they were kind enough to put out their cigarettes.

We had some breakfast in the room and we talked. John essentially said, “I am the one that will make an appointment of the next dean, we hope, because we want to get it done before I leave office; but, obviously, the person is going to have to work with Dave McLaughlin, so it seemed wise for us both to have a visit with you.” At the same time, [inaudible] subsequently whatever…What I got out of that meeting was from John Kemeny a sense that there were problems I had not been told about in the formulation of the relationship between the institutions to make a real effort to bring them together under the umbrella of Dartmouth-Hitchcock Medical Center.

Dave was quick to jump in to say, in essence, that “When I am there, I will knock heads together and it will come out all right.” He didn’t say it in those words, but he gave me the impression that he was fully familiar with all of it as the chairman of the board and that, as president of the institution, he was going to be sure that it happened and that it happened with appropriate recognition of the medical school’s role and responsibility and so forth. I really felt a confidence in the whole situation that I think I might not have felt even though I knew that John Kemeny had taken an active role in supporting Jim Strickler in a number of ways…not just that one because I had talked with Jim. I think that was, in a sense, a turning point in spite of all the smoke and mirrors. [Laughter]

I had no personal feeling about Dave as a friend or whatever because that was our first real meeting and it gave me a

confidence though in the choice that had been made of Dave as president and what he could do for the medical school. He seemed to be 150% for doing whatever it took to get the medical school not only on its feet financially and so forth, but otherwise.

Subsequently, I met with Dave again. I talked to him on the phone several times. The committee came down to a short list of two. I now know who the other one was on the list and Dave is now having his round with her. [Laughter] It was Bernadine Healy, or so I have been told. When I talked with Dave the other day, without betraying any confidences or whatnot, he let me know that he is really…He is having to pick up the pieces left behind by Bernadine Healy and they are searching for a new president of the American Red Cross. So it just struck me as being sort of funny that…Though he never told me who the other one was, I am sure he did interview with the other one as well, and it was probably Bernadine.

In any event, I expressed to Dave my concerns about it and then subsequently, when he in essence offered me the position without a lot of specifics attached to it, but said he hoped that I would accept and that we would work out all of the details. I said the detail that worried me most was the one that he had expressed such confidence in and that I really couldn't see coming here if this battlefield were still active. I knew they were meeting and meeting and meeting, trying to get it done. "Well," he said, "Is that the only thing that holds you up?" I said, "Well, in essence, that is because if that is not cleared out, I am definitely not interested in coming. If it is cleared, then I think there is a real challenge. I think it is something of interest and something…I could probably work out the other things."

I was in New York at some meetings in April and I think I had just stepped out of the shower that morning when the phone rang and it was Dave. He said, "We initialed the papers last night, or rather this morning about two o'clock, so the center thing is all settled. That's resolved and it has been a long, difficult process and it's over. So it's all okay. So are you ready to accept?" I said, "I would like to really see what had been initialed." [Laughter]

I came up for another visit and was given a set of Xeroxes with a lot of scratching and so forth. In a sense, it was sort of difficult to…I had never seen the document before, so I didn't know what it was so it was sort of difficult to go through it and get real assurance that it said everything I thought it said and so forth. But I did talk with Henry briefly and he seemed satisfied. What I guess I didn't realize was that, when you initial something, it signifies you plan to sign it, but it doesn't mean that you have signed off on it. So initialing something means "I read it and I am in agreement, but it still has to be put into final form before I will sign my name."

So I said to Dave after that, I can't be there July 1st. That's just, you know, I can't give Yale six-weeks' notice. I wouldn't feel right about doing that. Also I was due for sabbatical next year which, if this hadn't come up, I would have been all set and I would have been away come July 1st, but I have called that off. So I can't now go on sabbatical easily." He said, "Well, when could you come?" I said, "The first of January." "Oh, can't you come before then?" I said, "No. I really feel like I want to take some time off, number one, and I also want to give enough notice and be here to be sure that the transition will be all right and that I haven't just walked out in the middle of something." So he agreed to January 1st and he said he would then appoint Peter Whybrow [Peter C. Whybrow], who was the associate dean, to be acting dean for that period of time because he didn't think Jim Strickler, who already had plans for going away on his sabbatical, would want to reconsider. That seemed reasonable. I had met Peter Whybrow on a couple of occasions when I had been here.

So I came back up for one final -- no -- that was the final visit. I talked with Peter. Peter seemed quite prepared to do the interim job for six months. They had already lost the associate dean for administration, Don Penfield [Donald W. "Don" Penfield TU '66], who had said he was leaving the first of July and they had a search going for that position and they wanted me to make the decision for that person. [Laughter] So I ended up at New Haven, having people come down there for interviews. I wasn't going to come up here for every interview that they had and they had narrowed it down to four people, in any event, three of whom came down for interviews.

I made my first appointment from New Haven, even before I took office. That was sort of like Dave making his decisions before he took office. So that was all right. In any event, Susan Vogt [Susan Vogt TU '76] was the one I chose and was the most satisfactory appointment I could have possibly made. She was the administrator for Mount Ascutney Hospital at that time, which seems to many people to be quite a jump to go from that to being associate dean for administration. She had finished her MBA at Tuck, but she also had a master's degree from Yale in Far Eastern Studies and knew Japanese and had lived in Japan for a year or more. So I felt a closeness to Susan in a number of ways so that I felt comfortable with her.

In any event, that was my first appointment and I went back to Yale and told them I was leaving the first of January. They came up with offers. Giamatti [A. Bartlett Giamatti] was president at that point and he said, "What can we do?" and so forth. I told him it wasn't what they could do, because I had really made the decision almost certainly. I hadn't signed anything yet but that this was a challenge and I really felt that [after] thirteen years as chair of that department that I had done about all I could do there and I was getting burned out, quite honestly. In any event, that was it. As you may or may not know, when I went over to see Bart Giamatti, his office was filled with smoke. [Laughter] He was an inveterate smoker and did until his last day as far as I know.

In any event, the decision was made. I stayed on at my appointment at Yale until the first of January, but I took an abbreviated three-month sabbatical at Yale's expense, I guess. We took a trip. We felt that we wanted to have a real break between and, as a sideline, we got onto a little ship -- a red ship -- called The Lindblad Explorer, which had been around for quite a number of years, but went to very out-of-the way places and we picked it up in Bali and we got off in the South Island of New Zealand, having made our way through the Indonesian Islands and Papua, New Guinea and then down the Barrier Reef and across to the Lord Howe Island and then across the Tasman Sea to the fjords of South Island and then to Bluff at the southern tip of it and to Stewart Island, which is part of New Zealand that nobody knows. That's the southernmost. It is a little island and it is

all a national park. Then back home. It was a wonderful break, but as you would be surprised to hear, there were only ninety passengers. Well, there weren't even ninety on the boat, but we had given our address as being Etna, because we knew we were going to be leaving [New Haven].

So one of the first nights on board, a man came up to me and said, "Do you live in Etna?" I said, "We really don't live there. We are going to live there." He said, "Are you connected with Dartmouth?" I said, "Yes." He said, "Well, I am the class of…" It was Pug Atherton [Alexander S. "Pug" Atherton '35] and Pug Atherton was from Hawaii. He was the publisher of the Hawaiian newspaper. I have to admit I don't remember the name of the newspaper. So you can't escape Dartmouth. We have found that every time we go somewhere, we run into somebody from Dartmouth. They see that address and they pin you down almost immediately. So come December, we moved in in the middle of a snowstorm. [Laughter]

DAILY: That would be appropriate for Hanover.

McCOLLUM: The house had been flooded because of a broken pipe. It was a mess and the next thing we knew, there was a knock at the door. It was late afternoon. It was already dark. I opened the front door and there was Dave McLaughlin with a casserole that Judy had baked to welcome us. The place was just a nightmare. I said, "Dave, I would invite you in, but really everything is just sitting around the edge because they had to rip up rugs and the carpet and so forth." He said, "What are you going to do tomorrow?" I said, "We are going skiing." [Laughter] That was our introduction to the Hanover Plain and to living here, which has been a wonderful experience ever since then. That's how we got here.

DAILY: So from when they brought you up in December…would that be '81?

McCOLLUM: December 31 of '81. I think it was New Year's Eve because there was a big hockey game going on. Dartmouth vs. St. Lawrence or something like that.

DAILY: So from then until you basically signed on, what was it, about five or six months?

McCOLLUM: I signed on in May.

DAILY: Okay.

McCOLLUM: So it was about six months. I asked that it not be announced until I think it was May. I wanted to give everything at Yale clearance before there was anything from here. I think it was May the 19th or so.

DAILY: Okay. How did you find the medical school as you were kind of just getting situated and…Let me back up and rephrase that. How did you go about getting situated…just getting the information and making an assessment of where the medical school stood?

McCOLLUM: Well, I think first of all on my visits I did get around to meet every department chairman. I met with clinic administration and I met with hospital administration. I met with the VA [Veterans Administration] administrator at that point, so that I had an opportunity with fairly lengthy interviews and then, on the return trip, to repeat some of those visits and to talk to others who were not in such high-level positions.

Then I did two things. I called Howard Newman who had been the original president of the Dartmouth-Hitchcock Medical Center before it ever became that, really. I had met him on prior occasions. I really didn't know him very well, but I called to get his assessment because I knew he had left the post. I didn't know what the circumstances were under which he left, whether he was sent packing or whether he chose to leave or what and he didn't tell me. So I didn't ask him. He let me in on some of the things that he saw as problems that he hoped had been ironed out in the process of initialing this agreement.

Then the other person that I talked to at some length was Carleton Chapman, who was at Albert Einstein Medical School, faculty at that point. He had left Commonwealth, where he was president of the Commonwealth Foundation and had gone to Albert Einstein. He told me that they still maintained their residence up here and that they were up here quite regularly on weekends and on holidays and so forth. He remembered the visit that we had made, but he

didn't remember me. I didn't really expect him to. I just said that we had met only once and I told him. He said, "Oh, yeah. With Fritz Redlich…I remember that." So I didn't say, "Do you remember me?" He didn't say and I didn't ask. [Laughter]

We talked at great length about it because he had serious doubts that the problems that he not only remembered, but that he was still aware of because he was…You see, Jim Strickler was his successor and Jim had been his associate dean. So there was a communication there that was on going, so he wasn't out of the loop. He was not in the responsible line, but he was still, I think, acting in some ways as an advisor or confidant or whatever to Jim. He expressed a fair amount of resentment, I thought, about the way in which the medical school was treated by the clinic mostly, not by the hospital, but by the clinic. That there was a time when Bowler [John P. Bowler '15 DMS '17], who was the head of the clinic, was also the head of the medical school and that the clinic felt that it should run the medical school, quite the contrary to any place except Mayo, which it turns out, they held up as an example always.

You know, this is the Mayo of the East. Yet, they were nothing like the Mayo of the West. But, in any event, he expressed serious doubts about the reliability of opinions expressed from the clinic that I might have received or something they might have signed. I didn't realize the degree of reservation, I think, until long after that conversation. We talked for almost two hours on the phone. It was a long one. He was a talker almost as much or more so than I am; but he was someone I respected by reputation and by what he had done. In fact, I think at one point when we had made our visit here -- the group from Yale -- I wondered what the hell he was doing at Dartmouth. Here was this guy who was really a brilliant person, academician, historian and so forth, what did he come here [for]? I never asked him that question because, when he came, things were -- following Marsh Tenney [Stephen Marsh Tenney '44] -- in a building phase, but they were far from the promise of the future as far as I could tell.

I never really got to talk with Carleton in a more relaxed way when he could express himself perhaps more freely and that,

I felt, was a gap, that I should have taken advantage of when he moved back up here. He was here. He did some teaching and he was over at Dana quite regularly. I saw him casually in walking, talking or whatnot; but I never really got to know him to the point of being able to say to him, "Carleton, what did you really feel or think or whatever?" Or, "Why did you come here in the first place?" That might have been very revealing if I had had some real understanding. Jim may know, Jim Strickler. I've never asked Jim that.

DAILY: So you did talk with Jim Strickler?

McCOLLUM: I really didn't have a conversation with Jim. He purposely kept in the background. I saw him once, briefly. He didn't want to be a part of the process and I think I can understand perhaps why. In fact, when my successor was chosen, I decided that I had better not be a prominent part…so I didn't ask to see each one. I did meet Andy [Andrew G. Wallace]…but casually. It wasn't an interview situation. So maybe that was wise.

DAILY: When you arrived and kind of got your feet on the ground, what did you find that worked well at the medical center and what did you find that wasn't working well?

McCOLLUM: Well, let me tell you first what I found that was disconcerting.

DAILY: Okay.

McCOLLUM: Dave made a very bold presentation of his plan as president. Now he had been here for six months as president when I arrived so that he was already well known to everybody except me. He was very supportive when I came in, telling me, "We will do this. We will do that." and so on. One of the things…There were two areas that I was very concerned about. One of them was that the medical school had a $2.1 million debt to the college that I insisted had to be erased. I couldn't see with an $800 thousand deficit in the budget for the coming year as it was proposed and Dave's charge to me was "You have got to get it on a solid financial footing. We cannot support the medical school any further. The college can't …and the board of trustees will let you know that."

So my understanding with Dave -- and I talked with Paul Paganucci [Paul D. "Pag" Paganucci '53, TU '54] at length about it before I ever arrived here -- was that that $2.1 million would disappear and I would do everything within my power to get the $800 thousand deficit proposed for the coming year down to half that and to no deficit in the following year; that, if we had the deficit, we would try to cover that, but we couldn't cover the $2.1 million. Paul assured me that he could manage that. He was the financial man and that it would be taken care of. The second thing had to do with the academic …Because theoretically, the relationship with the medical center had been taken care of. I mean that was a done deal, supposedly.

The second thing was the relationship between the college and the medical school because I had learned during the process and the visits that the faculty of arts & sciences had no interest in the medical school; in fact, a disinterest in it and an antagonism to it. One of the worst of these was the department of biology, which was the next door neighbor and shared Dana Library and there was a glass bridge between the two institutions, so to speak, but no love. In fact, there was not a love/hate relationship, but a hate relationship. Dave had assured me that this could be overcome because the medical school had so much to offer biology and everyone knew that biology was a weak department and should be a strong one here and that, in fact, it had a reputation of not being a very good department.

I had talked with the basic science chairs in the process of all this who assured me that they could provide teaching that would strengthen the department of biology, physiology, microbiology, pharmacology and toxicology and the environmental aspects of biology; that we had a number of things other than biochemistry…

**End Tape 2, Side A**
**Begin Tape 2, Side B**

McCOLLUM: The department of biology was not receptive to any suggestions about how it was going to deal with its own academic content and presentation and its faculty representation. Dave apparently, even as CEO of Toro, hadn't realized that the faculty of arts & sciences felt that

they ran the place here. He didn't even know that, I think, as chair of the board of trustees, that you don't cross their lines by dictating from the top. That administrative style in academics is not necessarily an administrative style that works in a corporate setting. The chair of biology at that time actually just refused to even discuss anything with me. It was…If there could have been a barrier put up…

In fact, there was resentment when I parked over here and I walked through Gilman to get to my office. I shouldn't have done that. I should have gone the other way around, even though in bad weather it was easier to duck into Gilman and get through. I had not felt this before -- the level of it -- and it was through the department. It wasn't just the chair. But it had been there for ages. It had festered for a long time and it wasn't about to be cured by a sudden lancing and letting out the…You know, just nothing.

DAILY: What were the roots of this animosity? Do you know?

McCOLLUM: It is just turf. If you are not considered top level, you don't want to use somebody else's resources to get there and admit your deficiencies even though you can't get the funding from the college to improve your situation. This was quite the opposite from what I had experienced in bringing things together and using common resources at Yale where everybody seemed to welcome it, or at least I thought so. I never ran into anything quite similar to it and it was real resentment.

There was one member at the department of biology, Thom Roos [Thomas "Thom" Roos]. He was chair and he just, for whatever reasons, distrusted (that would be putting it mildly) any input from the medical school. So Dave, I discovered, didn't have the capacity or the desire to get into that hornet's nest I think when he had other irons in the fire perhaps. I don't know what they were in the college. Women? This wasn't the only…

We spent endless meetings when I first got here about the "Men of Dartmouth". How do you change the words? I couldn't believe it. This group of people would sit around a table like this…All the heads of everything were sitting

around there arguing about how you would change the words of “Men of Dartmouth”! [Laughter]

DAILY: It is hard to take that seriously, isn’t it?

McCOLLUM: Yes. But you know, it was that…There was a mystique about the place, the institution, that went back so far and there were so many alums who were so disturbed and the same with the faculty. There were a lot of faculty who didn’t want to change. They didn’t want any change.

So, you see, I had no concept of what that was. That was one of the things that really bothered me at first and then I realized that there were things that needed to be done in the medical school that probably had precedence over that. First of all, it was the matter of the budget and dealing with it and how to get from A to B without immediate sources of revenue and so forth.

Jim Strickler had taken care of a lot of this by forging this relationship with Brown because this allowed us to increase the class to eighty-five and, to put it bluntly, twenty more tuitions and we were at $10,000 a year tuition then and that was high. So we couldn’t easily just jump tuition up, but that gave us a real step up to have twenty more coming in. We went from the three-year school to the four so that we had an increase in the number of students who were here at a given point for a year because it is easy to calculate if you take twenty more and you have got them here -- sixty-five of them -- for four years instead of three, you have already made an incremental change in your budgetary base. But you also have a problem of getting students of the caliber that you want who are going to be offered packages at other institutions that are in competition and we weren’t competing with Yale and Harvard and Stanford and so forth in the student body easily.

DAILY: Who was Dartmouth’s kind of main competition for admissions when you got here?

McCOLLUM: Most of the second-tier schools, regionally, that were, you know. . . We had some with, not really with Tufts or with B.U. [Boston University]. It’s hard to say. It wasn’t competition as much as it was trying to get the level of students that we

wanted and to be able to give them also the feeling of being in a unique setting. That it is not just the setting here physically in this environment, but of a setting -- institutional setting -- that had an academic plan that wasn't the same as Harvard or Yale or Columbia or Hopkins or the others, all research institutions. We couldn't ignore that. We had to have a research base and that had to be built up, very definitely. We had to have an awareness that we also are responsible for a rural community here, not an urban setting and that we had to build something into the curriculum that signified our presence and our hope that we would supply positions to, let's say, general practice or family physicians. We couldn't sort of close the door. Yale and other places tried to close the door on family medicine.

DAILY: Oh, really?

McCOLLUM: Oh, yeah. This was not a welcome thing to be confronted with a…Constructing a department or admitting to faculty family physicians who would then want clinical privileges as well. We were going to face that problem here, too. That wasn't…We had no department of family medicine really.

DAILY: When you arrived, there was nothing?

McCOLLUM: Well, we had one that had been gerrymandered by Mike Zubkoff [Michael Zubkoff] and was a pain, believe me. That was my department. I had an appointment in that department. Still do. As Cary Clark [Cary P. Clark '62] used to say he was the only person in the Upper Valley who didn't have a faculty appointment. [Laughter] So I guess…I didn't try to press the college relationship thing in the beginning because that looked like something to get into that was going to be, if not impossible, would lead to more conflict and more disasters and I didn't have any need for those.

So, getting back to Susan Vogt, who naturally…I couldn't add my checkbook figures up and come out right and I had had problems trying to figure out budgets at Yale because the budgetary system was complicated and was not always at the discretion of the chairman, but had always to have the approval of the dean and then the approval of the provost and then the approval of somebody else. You kept going up this chain and I realized that I was really dependent on

Susan for that and she was tremendous. She took a lot of the brick bats head on and she also understood the intricacies of budgetary preparation and the follow through on it and of arguing. She was very good. Now she is vice president at Wellesley, so she has moved up. I still consider her as my best appointment.

My second best one --I didn't appoint, but he got here just before I did -- that was Stan Roman [Stanford A. "Stan" Roman, Jr. '64] as associate dean and he is now a member of the board of trustees and he is also dean of the Sophie Davis Medical School in New York. It is the College of New York medical school, but it goes under Sophie Davis' name. Those two saw me through many, many difficulties. Stan on the academic and student relations side, because he was the only associate dean I had. Now it would take you a page to write down all the associate deans. And Susan was my only administrative budgetary person, with the help of Dave House [David C. House] who had been here with Jim as well and with Don Penfield. So that had to take priority. Now I've lost track.

I guess I've dispensed with the academic relationships with the college for the moment. Then the real problem that was left, of course, was finalizing the initialed agreement between the institutions. The real problem turned out to be the clinic. You are going to interview Harry [H.] Bird [Jr.], but the person who preceded him is probably not on your list and that is Dick Cardozo [Richard H. "Dick" Cardozo '42, DMS '48], who was the president of the clinic at the time I arrived. He was a cardiac surgeon. The other person at the clinic then -- and I just found out a while ago he was at the meeting last night -- is John Collins [John C. Collins, Jr. '68], who was the power behind the throne at the clinic when I got here and I think still is.

The clinic was operating under the belief -- not the assumption, but of the belief -- that it would be far better if the clinic ran the medical school. But having come here just recently as dean of the school, they had a hard time working that one in a way that would make it satisfactory to me, so what they proposed was -- or what they kept saying (they never made it as a formal proposal) -- was that there should be a rotating head of the medical center. That the clinic

should provide the leadership for the center for three years, the medical school for three years, and the hospital for three years. This would smooth things out. I could never buy the idea that rotating that position would resolve anything, but it would give the clinic the opportunity to run things for three years for everybody. [Laughter] Sorry.

That was never proposed by the hospital that this would be a good solution. It never would from the VA [Veteran's Administration] because the VA couldn't do it. The VA is responsible to the Veteran's Administration, not to the medical center and the college, obviously, would have to be behind the dean of the medical school, I guess. [Laughter]

In any event, that came up constantly and this was one of the suggestions that John Collins proposed, but that Dick Cardozo voiced on several occasions with me. I could not see Dick Cardozo…He is a nice guy, but I couldn't see him running a medical school because I couldn't imagine that…You know, he was wonderful at running the clinic, which was a business operation at that point. They couldn't care less about academic aspects of their responsibilities or the fact that their appointment to academic rank carried with it any responsibility unless they were paid for it and they weren't our choice in any of this.

So, you know, we had a real obstacle to finalizing some sort of an agreement that would give the clinic a responsibility for a recognized and agreed-upon responsibility for academic performance and for financial backing of that performance through clinic resources. Now most medical schools -- or many medical schools -- at that time had clinical practice groups associated with the medical school that were run entirely by the medical school. Yale had one. We had our clinic practice group that were Yale appointments. They had clinical facilities through the hospital the same as private physicians did on the outside and had common privileges in the hospital. They were paid by the medical school. But those physicians in the community who had faculty appointments had them because they were expected to contribute half a day a week or more to clinical training of medical students, in particular, and residents and others. They did it without rumbling as far as I know. You know,

some of them gave a day a week; some gave a half day a week and whatnot.

I figured, if we could get a half-day-a-week agreement out of the clinic, we would be in reasonably good shape and, if they would accept people that we appointed to clinical positions who were doing research the rest of their time and give them the opportunity to work within the clinic in the same way that the clinic physicians did.

Well, that comes into the story somewhat later, but that was the basic plan originally which might answer some of those difficulties or respond to some of those difficulties. Just as the plan part relating to biology I thought had to wait until we had some opportunity for a quid pro quo or do something for biology that would be acceptable and helpful to them as the department of biology. We finally got that opportunity along the way. Then the financial one was one that we were working on and had a foot up thanks to Jim Strickler.

DAILY: Why was the medical school losing money when you came here?

McCOLLUM: They had commitments to salaries for faculty members out of proportion to what many medical schools had and I will explain it…but also to operating costs that were imposed by the college. You see, the medical school had its buildings. Those buildings belonged to the college. They are not medical school property and they have to be maintained and all sorts of college-wide costs that get assigned by square foot or whatever else and the medical school was unable, within its resources for income, to cover all of the commitments that had to be made to the college. So they would go into the debit side. So you would build up…I mean, that is the simplified way of expressing it. Your living costs were beyond your income and that the college imposed those living costs in a sense, so that they were charging you rent and you weren't able to pay your rent and it went into an account that says "you owe us this amount." So that was part of it.

The second is you can't make a budget on your resources that are coming in that will be in balance if you know that you are going to have to pay certain costs out that exceed that.

So you end up…If you are going to keep operating at a level that will meet accreditation requirements and so forth, you are going to have to commit yourself to more expenditure than you are able to raise. The one way of raising that expenditure at that point in time…still to a large degree…or there are two ways…one, you get more endowment, get more gift income or you get more research income. Endowment, that's not easy to raise, you know, and especially if you are working in a situation where the college gets it first off. Second, gift income…When you have got a small alumni body and you have no patient income gifts because it is all going to the clinic or the hospital…So you have lost out on those two right away and research from federal or other resources is your backstop, then you have to work on that one because you can't build up alumni giving overnight and you can't build up the research either overnight.

You are boxed in, so the strategy in the beginning was to look at the space that we had available for research, the people who were occupying the space, and the income they were bringing in. That's where you have a deficit because most research grants, you pay us for the researcher and his staff or her staff out of the research funds and you get indirect cost recovery that will help cover those things that the college is charging you for, for that space. So it is a win/win situation when you get that. Without that base, you've got faculty who have tenure or faculty who have partial support, but not full and you can't just kick them out the door. So you try to build up their research income by improving the use of the space you have at the present time. And you take space away from somebody…not easily. And you try to force somebody to do something…not easily because academic freedom and tenure carry with… You put a dean trying to get across that is death.

DAILY: What would be a good example of one of these battles over space?

McCOLLUM: Well, we had a professor in a department who felt he was world famous and nothing could convince him otherwise because he had been recognized twenty years or thirty years before for something that he found. He had a lab that was filled up with junk -- equipment that was no longer usable,

but he wouldn't part with it and he couldn't use it and he couldn't get research support. He had space. Trying to wrest that space from him or even get rid of the stuff so that somebody else could use part of it or he could use it more effectively turned out to be an absolute nightmare. I have to tell you, it ended up with suicide. I have felt…The suicide didn't happen on my watch. It happened right after Andy came; but I have felt the pressure of it initially because it was a battle I had fought. In fact, he took me to court essentially internally.

You know, you can…I tried everything to… That's not an easy thing to go through when you have faculty members who might share the same sort of problem looking at his situation and I tried to do everything to make it work for him. He was just an impossible person and everybody agreed; but that doesn't make you feel any better when, in the long run, you've gone through the battles and you have lost out. You know you can't get rid of him. You can't fire him. You can't…You know, he's got tenure. That's his space. It's not his fault he can't get research funds. We had more than one of these, but only one of them ended in suicide as far as I know. That weighed heavily on me. I finally got rid of that. You know, I did everything I could do. But it is that sort of thing where you have to pass judgment on somebody else's behavior and your only out is to do something that you don't want to do or it runs against your nature. But, for the institution, you have to try to follow through on it.

So our first thing was to get space used appropriately and build up the research base through improved grant support and whatnot. We got somebody in to help with grants and gradually that…

DAILY: Okay. Where, in terms of looking for grant money, where did you focus?

McCOLLUM: Largely at the N.I.H. That's the big bank, but you have to…That competitive a situation and you have to send in grant proposals that are worth it and you have got to help people who have been unsuccessful in their grants and you work through the department chairmen because it is their faculty and you don't work around them. Sometimes it is difficult for department chairmen to take somebody who has

been on his left hand or his right hand for ten years or fifteen years and say, “You have got to do something with this guy.” There were a few department chairmen who were prepared to do it. Some who simply couldn’t, so you work with their support, grudgingly given.

DAILY: So in terms of disciplines within the field, what were some of the areas that you felt were the strongest and you could kind of build on when you went to N.I.H.?

McCOLLUM: Well, the strength shifts and you can’t build on…Something that is strong, you don’t necessarily build on. You have to take the weak ones and try to work those out.

DAILY: Okay.

McCOLLUM: Because as long as you use the strong ones to try to support the weak ones, you are not gaining much ground unless you can take from the weak ones to give to the strong ones because they don’t need the expansion to improve their position. They might help improve the institution’s position, but only if you can do something with the weak side…You are supporting weakness with strength, but you are not making the weak any stronger.

DAILY: Okay. What were the weak areas?

McCOLLUM: Well, one of them was anatomy. Here we are…It’s not a department that gains stature by research that is not modernized, molecularized research. There are individuals in the department who, in some instances, were wonderful people, but they were long past their prime as researchers and you pay them full salary because they are a full professor. You know, although our salaries are not always the top of levels in the country, you can’t hold somebody back repeatedly although we did use that mechanism sometimes by not giving incremental salary increases to people who were not able to in some way help support their own salary. That has become now the key in academic medicine.

There are very few…Even endowed chairs don’t pay enough to support faculty members. So most of them have research grants that pay something or they have other ways of getting

funds that will support their department. I don't like this necessarily. On the other hand, that worked fifty or a hundred years ago when a professor's salary wasn't very much and, if they did reasonable research and [were] academically attuned to whatever, but things weren't moving. Now you can be ten years behind in three years. You get a research grant for three years and you find everything has moved ten year's worth.

So I am not offering excuses necessarily, but it seemed…and we got taken to task on it, for moving in this direction. But I think on the whole it ended up working. But we do have still…It is not my job to assess it. I think we have super annuated…Is that it? Somebody who is well over the…We've got departments that are heavy on the older faculty members. Now you can't have somebody, you can't say you retire at age 65 or 70. You can't do that any more. So if somebody wants to stay around as a tenured professor until he is 90 or she is 90 -- most of them wouldn't be "she" because there are not that many tenured…What do you have at your disposal? You are stuck with an even worse situation. Technically, I could still be drawing a salary from Dartmouth. [Laughter]

DAILY: Wow.

McCOLLUM: Doing no more than I am doing now. So…

DAILY: Were there other discipline areas that were weak?

McCOLLUM: Toxicology and pharmacology -- a changing world, but one that was very important. You know, environmental everything was coming in and yet the department was saddled… That's the one that committed suicide was in that department. There were several members of that department who were contributing nothing, not even to the teaching. Yet they were blocking space. They were blocking faculty appointment potentials and so forth by being there. So you have to deal with those and we had more than one in that department. They all threatened legal action internally within the college system or externally. They got a lawyer. What do you do now? You get a lawyer.

DAILY: I am going to close the day with…

**End Tape 2, Side B**
**Begin Tape 3, Side A**

DAILY: Today is July 3, 2002 and I am speaking with Dr. Robert McCollum, former dean of the Dartmouth Medical School. I thought we would start out this morning with kind of a big picture question. What changes were going on in health care delivery as well as medical education during the 1980s and how they affected both the DHMC relationship as well as the medical school?

McCOLLUM: Well, I think the major change that I recall as being a part of the early '80s and all through the '80s in medical care was the increasing degree of specialization, both in patient care and in research, and the difficulties of maintaining a relationship, in the faculty at least, between the research faculty and the academic teaching group and the clinical faculty who were responsible for teaching in the clinical clerkships of the medical students, but also responsible for medical care of an increasing population and of an increasing sophistication requiring more and more post-graduate training opportunities and resources as well as funding for those who were involved with it. I think that is where we had some of our major difficulties in maintaining a balance between what we had to provide for the community and that was done through the then Hitchcock Clinic and the medical school that provided the undergraduate medical education and was the official sponsor of post-graduate medical education as far as accreditation and many funding sources were considered.

So that we had a rather love/hate relationship at times with a clinical entity that was supposed to be doing two things simultaneously and in concert with the medical education program that was developing in a totally different way in the sense of increasing faculty and increasing research opportunities as well as research areas.

At the same time, there was a national surplus of medical school applicants in the beginning. Then, with the national program of trying to sort of maintain a fix on medical expenditures through a whole series of national political movements as well as insurance and other schemes for

paying for medical care, [that] made the attraction of medicine somewhat less than it had been before and we began to see those students in undergraduate programs more interested in business and in business school outcome and quick profits post-graduate and a decline, then, in medical school applicants. I put the two together because I think they fit, although no one ever proved that this was a quid pro quo in the sense of the decline in medical student applicants at that time.

DAILY: I was curious about that. I noticed that dip while I was looking at the admissions information for the med school. Was that about ’84, ’85?

McCOLLUM: It was in the mid-'80s and Larry Altman, who is the medical writer for *The New York Times* and has been for umpteen years now, did a series on the drop in the attractiveness of medicine as a lifetime profession and, in a sense, said that students no longer wanted to enter into it because of the uncertainties and also because of the certainties which were that they weren’t going to be quite as lucrative in practice as it had been before. I had some discussions with him. I have known him for many, many years. He came out of an epidemiologic background at the CDC as well, long ago.

I took issue with him on it. I never got around to writing the letter to *The New York Times* to counter some of his arguments. But I did take it upon myself to ask a lot of our students how they felt about it and it was amazing to me that no one really took this very seriously. They saw it as a temporary feature and not something long term, permanent. It indicated to me that their interest in medicine was founded not on the financial outcome in the long run nor on the vagaries of what practice might be like in the future, but more on their specific personal interest in providing something to society that would be sufficient for their lives, but not something that they would have to sacrifice too much for. At the same time, they were sacrificing enough to borrow as much as sixty to eighty thousand dollars so that, when they finished medical school they were so far in debt, it would take a long time to recover. That still goes on. That hasn’t been resolved.

DAILY: During that dip, was there anything the medical school admissions office did to try to cope with it?

McCOLLUM: Well, first of all, we felt that the cost of medical education was one of the prime deterrents for student applicants and certainly that was one of the things that we faced in our competitiveness with other medical schools was that it cost more to go here than it did…We were about the seventeenth or eighteenth most expensive school in the country. Though it is a wonderful setting to go to medical school, the beauty of New Hampshire, the Upper Valley, doesn't offset eighty thousand dollars of debt.

So we tried to figure out how we could best cope with that. There are two approaches to it. One is to increase the amount of student aid that we could provide and that meant endowment for scholarship funds. It takes a whale of a lot of money in a scholarship fund to offset one student's tuition for a year. We can improve their borrowing capability with a lower rate of interest. The other thing is we can try to keep the cost down in the first instance. In the latter, we did put a cap on the increase of tuition each year of not more than two percent.

In fact, inflation was considerably more at that time, so that we set our budget process that we would not count on more than a two percent increase in tuition. Other schools weren't putting that cap on, so that we began to find ourselves more in the middle than in the upper-cost category over a period of a few years. We also had established -- actually in the early '80s -- our own loan fund which could provide at a lesser interest rate than the others that were available at that time. This was through the generosity… It got started anyway through the generosity of, I want to call him "Colonel", but that was his nickname. It was Jim Vailas' [James C. Vailas '78, DMS '81] stepfather.

DAILY: Okay. We can…

McCOLLUM: He gave us a half million dollars to establish the loan fund. We were able to increase that through various financial moves that Paul Paganucci made that I don't understand. I left that entirely in his hands. Dartmouth also had its own loan fund. So he had already been through this process with

Dartmouth and he set it up for the medical school as well. So we tackled it from a variety of standpoints and then ended up coming out I think fairly evenly in the long run. It still operates largely on the same basis. But we have increased the endowment fantastically, so that makes for a lot more scholarship fund rather than loan fund.

DAILY: Is it fair to say that the lack of endowment when you came on board as dean was the major reason for the high tuition or were there other pieces of that puzzle?

McCOLLUM: Oh, there were other pieces of the puzzle. We were deeply in debt at that point and running at a real deficit on the budget side and we also had problems with our financial relationship within the medical center and that was a continuing problem over a number of years. It goes back to the same interplay between faculty appointments that were clinical primarily versus faculty appointments that were academic and research primarily.

DAILY: Let me pick up on that. With the clinic and getting them to go non-profit, that seemed like a major hurdle. Was there any precedent elsewhere in the United States for that?

McCOLLUM: Many medical schools had their own clinical practice plan. Yale had one…still has it I think in operation. The most extreme I guess of all of those would be Mayo Clinic which established a medical school on the basis of its clinical faculty availability and so forth. There were any number of others that had basic arrangements that were somewhat different from ours with clinicians who were not necessarily organized as one clinical group.

We were rather constricted here because it was the Hitchcock Clinic or it was no one. They were the only guys in town and we had that relationship and had had it for a long time and it wasn't something that you could break easily. The not-for-profit aspect of it, I have to admit was always held up as a carrot and I think it was hiding the big stick. It was extremely difficult to get it through. I think it was presented to us as something of much greater difficulty than it would have been if there had been a determination on the other side to do it.

The clinic also wanted to pull out of Hanover and go to Lebanon to the land that they had purchased next to Jesse's restaurant down there so the threat was constantly coming up…"We will move to Jesse's." That was the rallying cry that brought many of the older clinic positions right up to the front lines. They didn't want the medical school to run the clinic. They wanted the clinic to run the medical school. Now there are many who would take issue with that, but you had to be in the midst of it to realize how clearly that line was drawn and how difficult it was to convince some of the people who were primarily clinicians who had no research interests and would not even teach the medical students if it weren't sort of forced on them because they wanted payment for each hour for medical students. So we tried to work out arrangements for that.

I thought, if it were a not-for-profit, then it would be a much easier thing to put the profits that they had generated in the past -- because they were making money, there is no question about that -- put that into the education fund rather conveniently. It would make a good argument for the not-for-profit, as a matter of fact, if the relationship with the medical school were more clearly identified and adhered to.

We also had problems with the hospital at that time in another sense and that is, in most medical schools that have a close hospital tie -- a single hospital tie -- there was a federal program of support that was easily obtained and would pay for most of the resident training -- the post-graduate resident training -- which was becoming more and more expensive. When I interned, for example, interns didn't get paid anything. You got room, board and laundry sort of and that was it or you might get a pittance of a salary. We were entering a stage where most of our residents were married. They couldn't live on food that was provided by the hospital and starched laundry that came back once a week. So we wanted that to operate here.

For what reason I don't know, but the main financial officer of the hospital, with the backing of the president of the hospital and the backing of the board of the hospital, did not want to get involved with federal funds that would alleviate this expense. So it was considered that the medical school imposed this in a way on the hospital, but our solution for it

was rejected while everyone else took from that barrel -- maybe it was pork, I don't know -- whatever it was. I even had the chief financial officer of Yale Medical School talk with the person here about how it worked and so forth. It just didn't get through. So we suffered under that and that program is no longer in effect. So we missed out on it for a number of years. So there were problems. I keep referring or I have referred to them always as "clinic," but we had some problems with the hospital as well. On the whole though, we managed rather well.

As a part of this, by virtue of my office, I had a seat on the board of the hospital. You see, that's my entry point. The clinic president had a seat on the board of the hospital, so that was another one. Interestingly, about mid-way I guess the hospital board reorganized and I was made a non-voting member…[Laughter]…as was the clinic president…a non-voting member. Now that…You see, most of the members of the board, a lot of them were clinic positions, so that didn't faze it one bit.

We had a group of hospital trustees -- four in number -- who voted as a block always led by former Governor Lane Dwinnell ['28 TU '29], who was an anti-medical school person originally. He could never understand why the medical school couldn't pay its own freight and why we had to be dependent on or why we weren't paying the hospital for the privilege of using its facilities. There was…I guess it was [A. Wallace] Wally Cunningham who was one of the four who became a personal friend. I got to know him outside of the board and he invited me over one afternoon with Lane Dwinnell to his home and we spent an afternoon in front of the fire talking. Without my making any specific move from that, Lane Dwinnell turned almost 180 degrees and, interestingly in his late years, he became a strong supporter, long after he was off the board. He became a strong supporter of the medical school and gave us rather sizable gifts, part of which paid for the bicentennial celebration and for the book that, one of the books that has resulted from that. So, you know, even though you consider somebody an enemy at one point, along the way things will change or may change and, in this instance, it did.

So that our relationships with the hospital were rocky in the beginning, but we were always more in concert in our relationship with the clinic. Of course, now the hospital owns the clinic. [Laughter] This is another shift in the sands, which has made it more difficult for the medical school in ways that it never anticipated before.

DAILY: What do you think turned or changed Lane Dwinnell's mind that afternoon?

McCOLLUM: You know that is something I was unaware of at that time, but we got to know each other personally. Otherwise, we had met across the -- literally -- across the table at the hospital board meetings and he, Lane Dwinnell, was very conservative. I think he also recognized that I wasn't. [Laughter] I made some remarks I am afraid during the Reagan administration that didn't go over all that well. But that afternoon, it was simply just sitting in front of the fire talking and it wasn't all talk about the hospital or the medical school or whatnot. From that point on, we had a sort of personal recognition of each other outside of that board room. I would see him on the street and we would stop and talk or whatnot. We talked a little bit about Lebanon because he was never very happy with the fact that Alice Peck Day Hospital had not attained the status…You know, they have a Dwinnell Room down there now and that relationship was a rocky one during those years as well because we tried to take over Alice Peck Day Hospital.

DAILY: Oh, really.

McCOLLUM: At one point in time and I think everything was pretty well set on it and then it fell apart. But there was a tremendous resentment of Mary Hitchcock Memorial Hospital by many of the citizens of Lebanon who didn't like it for a variety of reasons perhaps, but one of the…I guess he was the mayor. He was whatever the chief officer was in Lebanon. He came to my office one day to object to this whole process and he said -- and I remember the words very vividly -- he said, "I would rather drop dead on the sidewalks of Lebanon than have someone carry me to Mary Hitchcock Hospital." [Laughter] I thought this was about as clear a statement of what he…[Laughter]

DAILY: Do you remember who was mayor at that time?

McCOLLUM: Well, I don't remember his name, but his business was the Dunkin' Donuts business and I remember that very well because I would rather drop dead on the street than have to eat Dunkin' Donuts. [Laughter]

DAILY: Okay. Do you remember what year it was, the conversation with Dwinnell?

McCOLLUM: No, I don't. It was probably '83 or '84…is my guess.

DAILY: Okay. I guess the other tack with our current conversation is medical education. When you arrived here in the early '80s, were there changes that you thought needed to be made in the curriculum and also kind of were there reactions or plans for change that kind of fit with what else was going on in the United States?

McCOLLUM: Well, the biggest change when I came was that it had already been decided and Jim Strickler had been responsible for the Brown/Dartmouth relationship. That meant that we had the opportunity at least of joining forces in some way perhaps with Brown. I think it was considered then that Brown was strong in its basic medical sciences, but under the guise of a university department more than it was a medical school. It had vast clinical resources around Providence far exceeding anything we had. We saw the possibility of expanding our clinical relationships because we did have a limited availability of clinical teaching here. So part of the plan had been to try to work out an arrangement with Brown.

Brown changed deans at that point and Jim Strickler had been working with somebody else. Here I was new and the dean there was new. He was much more inclined to want things to work out for Brown and understandably so. So these relationships that had been dreamed of, I think perhaps unrealistically…I don't know. The distance between here and Brown…it's not easy to drive back and forth. [Laughter] So the interchange of faculty…while we tried to do it…that didn't work out because people coming up here for lectures or to give a series, it meant a lot of time, a lot of travel and nobody was paying for this. We couldn't pay

Brown for it. Brown didn't want to devote too much coming up here.

Getting students down there into their clinical program was not as easy as we had anticipated it might be and so there was pretty clear separation. Once the twenty students from here at the end of the second year went down there for their two clinical years, they went there. They came back up for visits because they liked it here, but they didn't come back to do extra work here nor did others of our students go down there necessarily to be with them during the clinical years. So that interchange didn't really work out.

It is interesting that we still do this, but it is being reconsidered now. We have reviewed it and reviewed it over and over since then. I still think it was a good program. I still think it is a good one; but, like every other program, it undergoes every five or ten years or something a real examination. Is it doing what it is supposed to do or what's its future potential?

Otherwise, the change here was that we had a rather distinguished medical school faculty out of the '60s mold. It had not changed appreciably during the '70s as the school moved through the transition. You know, it was in a three-year for nine months segments and thirty-six months in three years. You can't do a lot of reworking the faculty because they are working solidly around the clock essentially. So I don't' think there were many changes, but increasing demands. I think the faculty was getting a little bit burned out during this, as well as students. So the faculty hadn't grown appreciably, although it had a few new appointments that were good ones and appropriate ones.

The thing that I think I saw when I came to visit…We had quite a number of faculty who had been here for twenty or twenty-five years or so and whose productivity in relation to either teaching or research had diminished. Without going into specifics, we had a few faculty members who were giving lectures from the same notes that they had used perhaps ten years before -- same notes and jokes -- as the students would tell it [Laughter] and really were not providing much in the way…They were taking up space and in sort of the clinical analogy, they were space-occupying

masses. They just occupied space, but they didn't do anything. That's being a little hard on it, but…

One of the things that we did immediately was look at the productivity of the faculty in terms of their income -- external income -- from research. There were a lot of them who were not paying their freight, so to speak; but they had come in at a time when there was an abundance of money in medical education from the federal government to develop this, to develop that and so forth. But those programs always had limits of a few years and they had played themselves out. There were one or two who hadn't had any external funding for a matter of several years and had no incentive at this point to do it. They had lost their drive academically in research and they were sitting there comfortably -- or maybe uncomfortably -- while colleagues at other institutions or even around them were going ahead with the flow. Trying to alter…You can't fire somebody who has got tenure unless they misbehave in some gross way. Very few of our faculty members were misbehaving at that time. So it was a matter of trying to find a more efficient use of the space to reduce some of that usage. We had a lot of space that was really being misused, not from the research standpoint, from the teaching standpoint. We weren't using it efficiently.

So we went through all of those changes and, at the same time, tried to bring in new faculty members while increasing the productivity and funding of those who were already here. There was no specific aim at one target or another. It was more or less general. But to bring people in requires money, too. You don't bring somebody in fully funded and with no space for them to work in. So it was a redistribution of space, a restatement of goals in terms of expenditures of what funds we did have and finding additional funds…both from federal sources and from private foundation sources.

DAILY: Was federal money harder to obtain in the '80s?

McCOLLUM: Yes. You know, it had been free flowing in the '60s and '70s. You could go with almost any proposal you had or they would come to you with offerings. That began to really dry up during the Reagan years. We felt the taps were being turned down and some of them turned off completely.

DAILY: A course that jumped out at me in terms of the curriculum was one called “Health, Society and Physician”. Why was that started? Was that different than other med schools?

McCOLLUM: Well, you will have to go back a step to say that we had a department of community medicine here years ago. Somewhere in the mid-'70s I guess -- I can’t remember now exactly when -- there was a great push for getting family medicine or general medicine recognized and treated as an academic field rather than as an…

**End Tape 3, Side A**
**Begin Tape 3, Side B**

McCOLLUM: When this announcement came forth that the federal government would be providing unusual funds for departments of family medicine to build them up for those schools who already had them or to organize them, almost overnight -- I wasn’t even thinking of Dartmouth at that point -- almost overnight our department of community medicine became our department of community and family medicine. [Laughter] I won’t draw any conclusions from that abrupt action. But in any event, we then developed this capacity in a very strange way because the clinic refused to accept the idea of family physicians being members of the clinic. And the hospital, under the clinic’s pressure and to some degree the medical school as well, did not want to have admitting privileges for family physicians because we had no academic supervision for them and no academic appointments of people who had the experience and the academic background and so forth to head it.

So one of my earliest false starts, I guess, was to get Michael Zubkoff, who was the chairman of the department of community and family medicine -- the department in which my faculty appointment existed as a matter of fact -- to try to get -- because he was anxious to get family physicians that he already had doing some teaching in his department, but they had no clinical base or privilege -- to get them recognized and to get admitting privileges. He had a very bright young man who was a board-qualified family physician, well trained and interested in research named Allen Dietrich [Allen J. Dietrich]. He was young, but I saw in him the potential for having a clinician head that group

because Mike Zubkoff, Ph.D. was in medical economics. He had no concept or entrée into medicine other than that and Mike agreed to it -- I think maybe reluctantly, I won't say definitely, but that was my impression -- and Allen accepted it. But after a year or so -- it wasn't much more than a year -- I think he felt things were being too difficult for a young person to try to handle a man's job. I realized that that had been a mistake, but to me it had seemed a very logical one at that time because we had no one else who was board-certified who had a faculty appointment who could do it. I thought he had the capacity to continue his teaching, his research and to take on that responsibility. It was a big, big responsibility.

That occupied…The family medicine thing occupied a lot of time and emotion for at least four or five years, including threats, law suits, including a lawyer from Vanderbuilt Law School whose specialty is medical education law, I guess. I don't know what it was…He was a friend of Mike Zubkoff's and Mike had appointed him as a member of the department in order to get him to be able to come up here and give a lecture once a year on…I don't know what he…In fact, I never knew what he lectured on. I won't get into all the background of that except that he then called me and told me he was organizing…or had been requested by an organization of family physicians in the Upper Valley area here to represent them in a law suit against the medical school and the hospital.

DAILY: And what was their complaint?

McCOLLUM: The complaint was that they didn't have privileges. They had no place where they could admit patients. Now they could admit them at Alice Peck Day, but they had no house staff. One of the delights of being in practice is, if you admit a patient to the hospital, you know that there is somebody there theoretically that will cover you at midnight tonight or on Sunday when you are away or on the Fourth of July or whatever. Alice Peck Day had no provision for that so you had to sign off on to somebody else who was also in practice who had no house. So there were a lot of reasons why they wanted privileges here. Also it meant more to them if they had a faculty appointment and could admit patients here than if they had to admit all of their patients to Alice Peck

Day or give up the patient to somebody else in order to admit them here.

We tried everything under the sun to work this out. The chairman of the department of medicine here at that time was George Bernier [George M. Bernier, Jr.] and George was adamantly opposed to anything that carried family medicine forward. He thought there was absolutely no reason for them to admit patients to the hospital. We had worked out a plan that I thought he would approve of of having a sort of vice chairman of medicine who was a family physician and who would take that responsibility away so that he didn't have to do it, but these would be members of the department of medicine. We wouldn't have to form a family medicine department and he would have charge of it. He would be responsible for it.

He left before that. He departed and went to become a dean at Pittsburgh. I don't know whether to escape this fate or what…but anyway, that brought the need for recruiting a new chairman of the department of medicine. Along the way came Hal Sox [Harold C. "Hal" Sox] as a candidate. Now Hal Sox had trained here, so he knew the place well. He was well recognized as an internist. He primary interests in internal medicine was primary care, not a subspecialty of this, that or the other and he was also interested in the organization of medical care as well and had made a fairly good representation in the country as a whole. He came from California, came from Stanford to here and I thought this was going…He was a good friend of Mike Zubkoff's. They got along very well and he was also a good friend of Tom Almy's [Thomas P. "Tom" Almy]. Tom had been the chairman of medicine in a rather disastrous period many, many years earlier but had maintained his residence here and his identity here and was well recognized throughout the country as the kind gentleman physician, academician, arbitrator for good causes and so forth. Very liberal and not very well liked by the clinic.

So this is a long way of saying where this program came from. It was Tom Almy's idea. He felt that we really needed to have some better way of introducing students to the community, to society and to the responsibility of the community and society. So he put this in rough outline

together and, since he had been a department of medicine member…and still had a professorship in medicine…Mike saw fit to give him an appointment in the department of community and family medicine as well where this could be located as an academic base. With Mike's enthusiastic backing then, it took off. But it was Tom Almy's idea.

It was Tom Almy's persistence with it that kept it going. It had, as you might have guessed, provided an opportunity for family physicians outside our usual faculty clinical setting to take part by giving sessions or by taking students and so forth out into the community. So that was it.

This was happening all over the country though. It wasn't just here; but Tom spearheaded it here and was a very successful person. Tom could also be very bitter at times when things didn't go just exactly his way and there was some resentment within his community here -- that is the Dartmouth Medical School and the Hitchcock Clinic -- about this program so that it didn't move smoothly and easily to fruition, but he did manage to get it through.

DAILY: So is this about the time that you start seeing the medical practices out kind of in the hinterlands…northern Vermont, New Hampshire, down in southern New Hampshire?

McCOLLUM: We already had some relationships there and we did send students out to various practices around…almost more so than those in the immediate vicinity…at lease it seemed that way. We also sent students out to Arizona in Indian reservations. That had been in place for a long time and that was done largely through Dean Seibert [Dean John Seibert], named Dean Seibert. He was also an associate dean at one point so it was Dean Dean Seibert. [Laughter] He had had experience with the Indian Medical Service and he set that up and it may still be going on. I'm not sure.

We also had, as a real outreach program, we had students going out for obstetrics to Los Angeles. Now, as you may easily recognize, in a population as small as the Upper Valley population is and as heavily weighted as it is on both ends by students -- supposedly not of the age of bearing children, but that is not entirely true, and older people who have passed that prime -- we didn't have an abundance of

deliveries to take care of sixty-five medical students who had to go through obstetrics. Alice Peck Day was not an outlet for us because we had no faculty there. So they didn't have many deliveries any way. The local hospitals in Claremont and then in Newport, which still had a hospital then, are the other regional hospitals, had no obstetrical service that we could put students in. So we sent them to California to Martin Luther King Hospital. I think that's what it is called. I can't remember for sure. We had a lot of students that went out there and they would deliver more babies in a week there than they would have delivered in six months here. [Laughter]

DAILY: That was a good solution.

McCOLLUM: So we had outreach programs that stretched all across the country.

DAILY: Now with community and family medicine and the DHMC, where…Let me rephrase this. The growth of community and family medicine…what kind of synergy was going on between that and DHMC? Or am I mixing two things together that shouldn't be?

McCOLLUM: No. No. You see this created a real problem because we had two senior faculty groups that met independently as well as together -- the basic science chairman and the clinical chairman. The clinical chairmen, without exception, did not like community and family medicine. That went all the way through the clinic, not just the chairmen, but most of the physicians as well.

The basic science chairmen were equally as cautious about community and family medicine because it wasn't basic science. It didn't have any physiology. It didn't have any biochemistry. It didn't have any of these things in it that they considered basic sciences. It was this never never land of how you organize medicine to deliver to the public and how you account for it and so forth and epidemiology…which they didn't understand and didn't particularly want. Biostatistics…which they couldn't understand and didn't see any need for. Things like that were all sort of centered over in Strasenburg [Hall] with a guy they didn't like as the chairman of it. He had come here as the youngest chairman

-- now with the longest tenure -- and he didn't fit. He was a real misfit and he knew it and he would acknowledge it I think if he were sitting here at the moment, so that he never failed to go to these meetings of the basic science chairmen because that's where he had been assigned, but the moment he had family medicine as part of it, he considered that it was a clinical department. But the clinical department said, "We are clinical in the center here. He is not clinical in the center. Therefore, he doesn't belong in this group and keep him out." So I took a few brick bats on that, but I kept him out of that setting because it would have been very disruptive and I would have lost whatever control I had over that group anyway.

Once we had family medicine more clearly identified and worked out an arrangement for admitting privileges (still not quite what they might be) then he said he was "clinical" and he joined the clinical group. But that was after my time, so I won't get into that. [Laughter]

DAILY: Okay.

McCOLLUM: There were a lot of other changes going on in medical education, as I indicated earlier, with the tremendous expansion in research and in clinical work as well in the subspecialties areas and you couldn't keep up in a small setting as we had and in this sort of remote area with things that were going on in Boston or in New Haven or in Philadelphia or Chicago or San Francisco. We just didn't have that capacity to respond quickly, but we were trying to build consistently better strength and more diversification so that we wouldn't be caught short on accreditation.

DAILY: What did Dartmouth really become known for then under your tenure, both in research and as well as more of the clinical side of education? What would make it stand out against, say, Yale?

McCOLLUM: I could try to dream up something that would give you an answer to that. I think still the thing that Dartmouth had going for it was not that we had some super specialty recognition in some area or another. We had good solid recognition in the basic sciences -- most of them -- and in the clinical. We had good people and we had developed I think

one of the major programs here clinically in the newborn area with Saul Blatman initially and then with George [A.] Little heading it up after Saul's retirement. But we didn't have any real program in cardiovascular surgery or whatnot. We were building on those and, during that period of time, we got a vascular surgeon in. We got a new cardiac surgeon in. These were largely done through conviction on the medical school's part that we needed it and on the clinic's part that it could be paid for out of clinical income. We weren't buying these people. But we did manage during that time to get recruits who had good academic backgrounds and had research interest. That paid off because then people would be referred here regionally who might be referred otherwise to Boston.

We did have a problem during that same period though of beginning to lose VA support in some of these areas as the patient loads in the Veteran's Hospital went down and as funding for the VA went down and as orders from headquarters in Washington came through that we had to close this or close that at the VA because the VA's offerings were not necessarily subject to our approval or disapproval. There was that other layer at central office in Washington. That was politically, as well as budgetarily, restricted. So we did have expansion but we were not recognized for some innovation or some new discovery. No Nobel Prize being awarded or whatnot.

The thing that held us in esteem was our location and the feeling that people had when they came here that they were part of a medical family, not part of a huge institution located out on First Avenue with everything thirty-three stories above where you were. I think people who came here felt it.

Also you might recall that we had AIDS coming into the picture at that time. This was taking an overwhelming amount of medical attention, both clinical and research. We had essentially no AIDS here. Students or prospective residents, going for interviews in New York at Bellevue or at Presbyterian or New York Hospital and whatnot were overwhelmed with the fact that their lives would be centered around AIDS and around violence. They would visit in the emergency room…they were loaded with gunshot wounds and drug addiction and AIDS. They would come here for a

visit. They would see a chainsaw accident in the emergency room, rarely then, a gunshot injury.

They would see almost no drug addiction. It was here but it wasn't a major thing and they saw essentially no AIDS. There were a few cases, but not many. They were beginning to drift up in a sense...guys in particular returning from New York coming home to the Upper Valley to have their last days. I mean that was the way it was faced then.

So we were attractive. You wouldn't be spending your entire internship in the emergency room or on AIDS. This was openly expressed by a lot of them. The other thing was that they liked the people they met here. They weren't high-powered. You know, they had gone through college expecting that they wanted everybody to be Nobel Prize level anyway and the sort of reception they got here in the interviews and so forth, they had the feeling that this was like going home. It wasn't high powered, but they could get what they wanted in an atmosphere and surroundings that would be conducive to enjoying medical school or internship. So we had things going for us that were totally unrelated to what we had to present in the way of stellar performance by faculty.

DAILY: That is interesting. Were there differences in the students here at Dartmouth Medical School…differences between Dartmouth students and the students you had down at Yale?

McCOLLUM: Yeah…

DAILY: In terms of their expectations?

McCOLLUM: Yeah. I think so. Very definitely. They followed essentially the same pattern. We didn't have the over-achievers, for the most part. Those that we did have who fell into that category were very likely to have been Dartmouth undergraduates who wanted to stay for another four years rather than go to Boston or go somewhere else. We tended, and I don't say this out of disrespect for the students at all, but we tended to get more second level students than the top, top level.

You know the old story goes that guy that says he graduated from Harvard Medical School and he was in the lower half of

the class, but that's higher than the top of the class at most medical schools. Well, you can cut medical students any way you want across and you are very likely to get students who qualify -- they may have different grade point averages in undergraduate and they may have done differently on the various entry exams and so forth -- but they are all top level. So you try to divide them up into thirds or fourths or upper half or bottom half or top ten percent and you have honor societies that will pick those that are at the very top, but you can go to the bottom and find equally as good, maybe better sometimes. It just depends on how you are looking at them.

So I am reluctant to say that ours were any different other than that, on the whole, they would not pass muster at Harvard or at Hopkins or even at P&S. Well, some of them would, but the majority wouldn't. But that doesn't take anything away from them.

DAILY: Let's go back. P&S. What does that stand for…before we leave this.

McCOLLUM: That's Columbia University's medical school. It is the College of Physicians & Surgeons and…I don't know what it does now since they joined up with what used to be just plain Cornell and is now Weill Medical School. If somebody gave us a hundred million, I guess we would change the name.

In fact, there was a funny ad that I don't think was ever published in *The New York Times,* but it was presented to me as though it had been, that said, "Would you like to have a medical school named after you? For twenty-five million dollars, Dartmouth…." [Laughter] Since we already had Tuck and Thayer, it was…Many people wondered why we didn't get a major donation and change the medical school.

Well, there was a wonderful vice president at Dartmouth for development for umpteen years named Orton Hicks [Orton H. "Ort" Hicks '21 TU '22] and Orton and I became good friends as he tried to be helpful in my quest for money for the medical school. You know, there was always a little bit of friction between Blunt and medical center development, medical school development. I won't go into…There is no point of going into all of that but Ort told me…We talked about this one day and he said, "Oh, yeah. There was a lot

of talk about that." But we had a very generous donor to the medical school that I had become very friendly with and developed the friendship, not necessarily with the idea that we were going to ask for a lot of money, although I knew she could give a lot. I had no idea how much.

Ort was a very good friend and one day he came to me and handed me a Xerox of a letter he had sent to her and it said "I had a dream last night, Ruthie, dear. I had a dream last night and that dream was that you had come to Dartmouth with a check for twenty-five million dollars and that we were going to change the name of the medical school to the Chilcott Medical School." [Laughter]

Well, I can tell you that if Ort hadn't been a very good friend of hers, that letter wouldn't have gone and she laughed about it. She said, "Where do you think I would get twenty-five million dollars? If I had it, I would give it to Dartmouth, but I don't have it." Well, in the end you know, she was the most generous benefactor because, when she died, her estate was left -- the residual estate -- was seventy-five percent to Dartmouth Medical School and twenty-five percent to her church, which she dearly loved. So we ended up with fifteen million dollars, but no name other than through other gifts that she had given, we had the Chilcott Professorship, the Chilcott Scholarships, the Chilcott Auditorium, the Chilcott Conference Center out there and another million dollars toward other building funds. So all the way along, she had the twenty-five million. I think it was there, but we never named the medical school for her.

DAILY: That raises the whole issue of fundraising in terms of your responsibility for it. One thing I noticed in looking at the agreement between the clinic, the med school and the hospital -- I want to make sure I understand this right -- was that up until 1987 I think, the college development office would assist with the development down at the med school. Was that a cutoff date then to just put the medical school development office on its own or what's the background?

McCOLLUM: Well, when I came here, the medical school had its own development officer and staff. It worked reasonably effectively. It was a love/hate relationship with Blunt. I don't know how to explain it other than that there was

communication, there was common use of the computer system that listed all donors in the same system because many of the medical school donors were college donors as well. The agreement -- unwritten as far as I know because I never saw anything in writing about it -- was that the college had to approve of any requests or contact from the medical school development officer to anyone who had a connection with the college. In other words, "priority came to the college and you don't touch anybody without our approval and cooperation" or whatnot. Needless to say, if there was a donor who was a good prospect, the college wasn't anxious to share it with the medical school even though the interest might have been expressed for the medical school. Bill Morton [William H. "Bill" Morton '32], whom I think I mentioned before who had been the savior of the medical school when he was a member of the board…

**End Tape 3, Side B**
**Begin Tape 4, Side A**

McCOLLUM: Bill disagreed with this vehemently. Now he never became a major contributor to the medical school itself because his priority was to give to the college, but he and his wife both did contribute to the medical school and she became more concerned with the medical school after he died than she had been before. In fact, her major gift was to the medical school in her bequest.

Somewhere in the mid '80s, we had a change of the development office in the medical school as we tried to work more effectively with the hospital and clinic. The clinic had its own foundation, the Hitchcock Foundation, which in many places would have become a part of the medical center fundraising effort. They were very protective of it and wanted it independent because they felt they got more income from their endowment than would have been allowed through the college system that controlled our payback on our investments. So that never worked out. They kept that foundation quite independent.

The hospital had its own fundraising department which Orton Hicks, Jr. [Orton H. Hicks, Jr. '49 TU '50] took over and it was largely local, largely -- as somebody referred it to as -- penny ante. It harked back to the days when the hospital's

fundraising, not even fundraising…People brought food and left it out in front of the hospital one day of the year. [Laughter] The farmers all brought part of their harvest in and donated it. It was that sort of thing which was appropriate to the area, but no really major fundraising. Although he had entree to a lot of people in the area who had Dartmouth connections (as he did because he was a Dartmouth graduate) and who had the means to give. He was somewhat helpful, but he was not a major mover in going out for funds.

We decided then to go all together in one fundraising effort with the clinic sort of out to the side. It didn't want to play any part of the fundraising effort, but the hospital agreed to be a part of it and we went searching then for a new director and Bill Fissinger [William D. "Bill" Fissinger] came in as that person. The relationship between our development office and Blunt was an uneasy one. It was decreed by Dave McLaughlin that our chief of development had to report to Blunt. Now I hate to tell you that I can't remember who the person was who came into Blunt at that point. He is now living back in the area here and I see him occasionally. He didn't last. He was there for only two or three years and there was never a good working relationship developed during that time. So, quite honestly, I can't remember what in the center agreement there was specifically about it, but it never worked.

We went off on our own. We got in then to the major campaign for raising the money for the medical center right on the tail of an attempt to have a campaign before that that would be for the medical school. That was put into place really about the time Bill Fissinger came and we were not terribly successful in it because we knew the other one was coming along and you can't go to the same person two years in a row with two different campaigns, so we held off really on pursuing that one until we could get the medical center one in place.

We had no idea about that one until the decision was made to move out to [Route] 120 and have some idea of what the cost was going to be, whether the whole medical school would be moving or only part of it, and what the college

would be willing to provide in the way of compensation to the medical school for space it was giving up here.

I won't get into the whole tangle of that, but there was a lot of misunderstanding about it and, thanks to the tape recorder, we had [Laughter] that understanding expressed at a faculty meeting by the president of the college and then his telling me later that I was trying to write history or rewrite history. [Laughter] But anyway, it was a twenty million dollar promise that was then denied subsequently that would have made quite a difference in the long run. You win some and you lose some.

You may have guessed that the president was Dave McLaughlin. Dave and I did have some differences at times, along with some of the other administration in the college who didn't understand the hospital and the medical school and the medical center quite the way I thought they should. I think that relationship probably was better subsequently until John [C.] Baldwin took over and I am not accusing him of anything because I think he was the best dean we ever had. He was one who was not going to take anything for granted out of the past and was going to be forceful in moving the medical school ahead. Fortunately, it was at a time when the medical school was financially sufficiently independent to be able to do some of the things that it couldn't do in the past. We had a period of time when the development office was not functioning adequately and we came short on our goals for the campaign for the relocation.

DAILY: So is it fair to say that, between the not meeting goals of the campaign as well as decisions made over at Parkhurst, that is what really kind of impeded the move, the relocation? That is a real summary view. [Laughter] And I don't know how much you want to go into the details of that whole issue of relocating the med school.

McCOLLUM: Well, the relocation was largely a matter of whether…First of all, the town of Hanover wasn't going to let us build here. That became abundantly clear. They were fearful more -- they said -- of the traffic it would create than anything else. On the other hand, I think the traffic is worse now, or it couldn't have been any worse.

The second part of that relocation though was the agreement between the three institutions about a common location and getting all of it out there. We had a lot of people who felt that the medical school should be totally located there within the medical center and I was one of them.

We conducted a study of all the medical schools in the country by sending letters to all of the deans. "If you had this choice, what would you make?" and it was almost unanimous because there are many medical schools that have split locations and, you know, they function very well but they wouldn't necessarily choose that. Presenting that didn't help very much.

So we ended up having to go the split way and that then, in a sense, determined the proportional representation that we had in the fundraising efforts for the new location, reducing the medical school's part considerably because of the twenty million we didn't get from the college that would have to cover the buildings we were having to maintain on campus here. But we did come to a stage in the late '80s of working together on the plans for the new center that really brought a feeling, in my mind anyway, that we had overcome most of our past differences in a common effort -- a common project -- where we all saw something entirely new that would not only bring us together physically in a more congenial and inviting atmosphere, but would also bring us together in an administrative way in a sense that we had never had before.

So it was a unifying thing, very definitely. On the whole I think it worked…You know, you are trying to solve a common problem and you all have to give and take and give and take over the negotiations of not only design, but of responsibility, space and so forth. I think it came out very well.

DAILY: I know that the faculty -- the arts & sciences faculty -- opposed the move, from what I understand, because of losing the basic science faculty out to 120?

McCOLLUM: No. I think that was less because there was no love between the faculty of arts & sciences and the basic science faculty and the medical school. They would have seen…First of all, they resented the fact that the college was

giving the hospital twenty million dollars or twenty-five million for the old hospital and it was going to be blown up and getting only a few acres of land for that amount of money. This was violently opposed by, I presume, most of the…at least those people who speak out in the faculty of arts & sciences. I always have to recognize that a few people can make a lot of noise. It's a large faculty and most of them didn't care. But in any event, Dave and Pag -- I think Pag was still involved although even though he had left and gone to New York at that point -- worked out a plan for the college to pay to faculty of the arts & sciences with a huge sum of money, equivalent to what they paid for the hospital.

Now this is shifting bags of money around in a…You know, at Fort Knox, you put it in one room and then you take it and put it in another. So, in any event, this seemed to mollify the faculty of arts & sciences that they were getting an equivalent amount of money. Therefore, it was all right for the college to do it. I am not sure they all bought that, but anyway, it worked out.

The only thing is that it didn't work out for the medical school faculty because we thought we should be getting our twenty million as well. [Laughter] Even so, the faculty of arts & sciences did not approve of the move of the medical school for that reason plus whatever else and I am really not entirely sure what those reasons were. But it was at a time when they were having troubles with Dave McLaughlin anyway, unrelated to the medical school. This just added another layer on.

So it is hard to separate those faculty reactions that were directed at the medical center move versus those things that were totally unrelated to the medical school that were arising from Parkhurst and often late in the night. [Laughter] So I can't really…I had a number of friends on the -- believe it or not -- friends on the faculty of arts & sciences, not the deans and certainly not the provost in any of these instances. [Laughter] That's where I had my most volatile interaction, I guess, at the provostial level because Dave left and we were just in the midst of things at the point.

DAILY: I wanted to ask you about the working with the provost and John Strohbehn comes to mind, obviously because of the…

McCOLLUM: Well, it goes before that.

INTERVIEW: With Ag Pytte [Agnar Pytte]?

McCOLLUM: Ag Pytte. When I came, I did it with a very loose sort of a verbal understanding with Dave McLaughlin and then with Paul Paganucci relative to many of the financial aspects of the medical school. But one of the things that I had asked for was, knowing that the medical center and medical school relationship was in some ways more essential and stronger than the medical school and college one, and to have the medical center and college relationship functioning under my control essentially…

So I asked Dave initially about an appointment as vice president for medical affairs, which was a common thing then in most medical schools that the dean had a relationship with the college or the university as a vice president for medical affairs. Because in all instances, the medical schools, the medical centers were expanding and the college or the university had less and less capacity to deal with all of the ramifications of those relationships and Dave said, "Oh, the thing is, we don't like a lot of extra titles and so forth. You will have that responsibility, but, you know the title isn't necessary."

So I said, "Okay." But I quickly found out that, without the title, you didn't have the recognition or the responsibility and, whether Dave recognized it or not, the faculty of arts & sciences didn't. The medical center people didn't and, therefore, the relationship with the college flowed once again through the provost. This was what I was trying to avoid.

I felt the provost should have academic responsibility to the…with the relationship between the college and the medical school, but shouldn't have the responsibility of the medical school's relationship to the college through the medical center; that the dean was in a far better position to represent the college and to represent the medical center and the college.

But Len Rieser [Leonard M. "Len" Rieser '44] was the provost at that point. I think he was…I think he was provost

and dean. I'm not quite sure. He had a joint appointment, I think. Then when Ag Pytte was appointed, I found that more and more, I was being excluded and that Ag was…Dave said, "Yes. That's the way it should be." So we were back on that track.

Well, there were many occasions when Ag and I did not see eye-to-eye on something and he was resented by the hospital and by the clinic. They simply didn't like his representation of the college or his speaking for the college, particularly in instances in which I had expressed one thing and he would come in and counter it. So this was not an easy relationship. You know, I could go into a lot of detail on those things, but I will just say that that was it.

**End of Part One**