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

An Interview Conducted by

Daniel Daily

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INTERVIEW: James Strickler

INTERVIEWED BY: Daniel Daily

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DAILY: Today is September 17th, 2002, and I'm speaking with Dr. James Strickler, Dartmouth class of '50, Dartmouth medical school '51, and former dean of the medical school.

The question I'd like to start off with today is, What attracted you to Dartmouth as an undergraduate?

STRICKLER: Well, first of all, Dan, you have to understand that I was born and raised in a very unattractive city at the time – Pittsburgh, Pennsylvania. It was really at its apogee during World War II as a steel-producing center. About a third of the nation's steel was produced in Pittsburgh, it was a heavy coal mining area, it was a smoggy, dirty city. And although there were many things about my boyhood that were pleasant, I did not like the city in which I grew up; so one of my first objectives in selecting a college was go somewhere outside of Pittsburgh, Pennsylvania.

I had also, during my boyhood, gone to summer camps that got me into the mountains and the out-of-doors in mid-Pennsylvania. The camp that I had a lot of experience in, actually, a camp that had been founded, in part, by my great-great-grandfather, and one of the active members of the board was an uncle of mine, was in mid-Pennsylvania. That camp was close to Indian Town Gap, which was a military base. During World War II, they developed an artillery range and the camp was closed because it became part of the military range. So I went to a couple camps in the forties that didn't appeal to me in the area.

Then serendipitously, through my uncle, I got a job at Little Lake Sunapee [NH] after my junior year of high school and was a camp counselor in New London on Little Lake Sunapee. And I was so taken with the pine forests of New Hampshire and the beauty of this part of the world that I began to think about going to school in New England.

Then when I returned back to Pittsburgh in my senior year in high school, a friend of my father's said that he heard that Dartmouth College was a very fine school and that they had a particularly strong premedical program. One thing led to another and I got the Dartmouth catalog, as did two of my classmates because we were all friends together. Somehow or another, we all decided that Dartmouth was a school that would appeal to us a great deal.

They had a couple strong Dartmouth alumni in the area, one of whom was Bill Eaton [William Choate “Bill” Eaton n’17], and we were interviewed by these alumni, who were quite successful businessmen. Bill was vice president of Gulf Oil at the time, I think, for Goodyear Tire Division. They were very effective in telling the story of Dartmouth, so I applied. I had never seen the school, even though I'd gone to camp nearby.

Now, another factor was, World War II was still on, and I knew I had to go in the military when I turned eighteen in June of 1945, as did most of my classmates. We were not fixated on applying to a number of colleges because at that time, pre-atomic bomb, we expected the war to continue on for several years, so our orientation was, What branch of the military are we going to get into? But I was persuaded to at least apply to one college and go through the process and get in, if I could. I didn't have any idea that an acceptance at that time would carry over for several years, so I applied to Dartmouth. It was the only school I applied to, and I was accepted. And that's the story of my coming to Dartmouth.

DAILY: How did you find Dartmouth when you got here? What activities did you get involved with?

STRICKLER: My Dartmouth experience was not an optimal experience – my undergraduate experience – through no fault of Dartmouth. I went into the U.S. Maritime Service, and it was essentially an officers candidate training program when I entered an eighteen month crash course, at the end of which qualified you to be a third mate in the merchant marine and also an ensign's commission in the Navy. And at that

point we were told you could go either way, into the Navy or the Maritime Service. Just as I was about to complete my eighteen months and be commissioned and get my third mate's ticket, Congress changed the law, made it a federal academy, known as King's Point. Although I loved the sea and had six months sea duty, I did not intend to spend my career either in the military or the maritime service. So when the government ruled that another two years at King's Point would be required for graduation, I resisted.

And I had made up my mind I wanted to be a physician. So I came to Dartmouth in the last midyear class that was admitted. I arrived, I think it was in early February of 1947. I was admitted into the class of '49 originally, but after I arrived, they said, "You have your choice as either being identified as a '50 or a '49," and I said, "Well, I'm coming in with the class of '50, why don't I switch?" Ironically, it turned out that in college most of my closest friends were in the class of '49. (chuckles)

Now, the reason I say my experience was not optimal is that I arrived in midwinter. I'll never forget coming into White River Junction, taking the train up from New York, an interesting train ride but very uncomfortable. We left Grand Central at midnight and arrived here after, I think, an hour layover and train change in Springfield. We arrived in the morning, and I stepped out. It hadn't snowed for several days, but there was lots of snow around. There were still steam engines. The snow was dirty with soot, and I looked at it and said, "My God, Strickler, this is like Pittsburgh, Pennsylvania, which I've been trying to escape." So my initial reaction to White River was not favorable.

When I moved to Dartmouth, I missed the freshman indoctrination activities and I never really bonded with the major portion of my class. There were a hundred and fifty of us who came in, and all of us had been in the military in that group. We were nicely welcomed – I don't mean to imply that we weren't – but we were just out of sync. Also, coming to Hanover in February is not as appealing as it is when you arrive in September.

The second thing that happened is that I was premed, and the premedical curriculum at that time was prescribed, and it was a very intensely scientific curriculum. We were told we had to major in chemistry and zoology, and we had a whole series of courses to take in the sciences, much more rigid premedical curriculum than we

require today. So I immediately was out of sync in my major science courses. I couldn't take freshman chemistry my freshman year because they only offered it once a year, and that threw me out of complete alignment in my chem courses. The same was true in physics, et cetera. What it really meant is that I had to double up later on. For example, I took a sequence of courses in my junior year that would be totally unacceptable today. In the fall of my junior year, I took organic chemistry, physical chemistry, qualitative analysis, and physics, all of which had lab courses. That was just too intense. I went to class from eight to six.

So my experience at Dartmouth was distorted through no fault of Dartmouth College. And I had a wonderful undergraduate education. I am very positive about my educational experience. I was positive about my classmates. To the extent that I could, I enjoyed the out of doors. But I really didn't get involved in activities to the extent that's desirable for undergraduates. And I was also a little bit cynical about some of the activities because I'd been in the merchant marine for a couple of years up and down the coast of South America and had the attitude of many people who had been in the service: We don't need this Mickey Mouse freshman stuff. So I missed out on a lot of the better college experiences, but that was no fault of Dartmouth. It was circumstances at the time.

The bottom line is I had a damn fine undergraduate education and particularly in my chem major. My chem department was outstanding. In fact, that's one of the reasons I came to Dartmouth. I had heard that the chemistry department was an outstanding teaching department in chemistry.

DAILY: Are there professors you have certain memories or recollections of, out of chemistry or other departments?

STRICKLER: Oh, yes. Well, in my undergraduate class, chemistry, Professor Hartshorn [Elden B. Hartshorn '12] taught organic chemistry. He was a dry lecturer, droll, but meticulous, and we learned organic chemistry, largely by rote, but it was ok and I enjoyed it. Fletcher Low ['15], who taught qualitative and quantitative analysis was an excellent professor. Amsden [John P. Amsden '20] in physical chemistry was one of the best profs I've ever had, because he took a complex subject and made it relatively simple for premedical students. I'm trying to remember the name of my freshman inorganic professor. It was "Cheerless Richardson" [Leon Burr Richardson '00]. I do

remember he was a disciplinarian, and if you arrived at class at 8:01, the doors were locked. I can remember that. Now, coming from the military for a year and a half, that didn't particularly trouble me then; today it would drive students crazy.

Now, my most memorable educational experiences at Dartmouth were actually three courses. There was a classics professor by the name of Royal Case Nemiah who was a true classicist, who prior to World War II, taught the classics in the original Greek and Latin. Royal Case was dismayed post-World War II that students didn't sign up for the classics in the original languages, and he was more or less forced to teach the classics in English. He put together a course on classical civilization, which I took for a year. It was one of the best courses I've ever had in my life. Without going into detail, we went through the classics with a charismatic professor with a sardonic sense of humor that was delightful. That was a great experience.

The other was a course in political science by Donald ["Don"] Morrison in the poli sci department, and that was an outstanding experience. We focused, the course I took, on the history of the Balkans.

But one of the best experiences I've *ever* had educationally was the Great Issues course, which was run by the president, John Dickey [John Sloan Dickey ‘29]. There's no question that John directed the course, and an English professor by the name of Jensen [Arthur E. Jensen '46] actually managed the course. But Dickey was present at almost all of the sessions, certainly the ones with the major outside speakers. It was a course that I know fell into disrepute some years later, in large measure, I think, because of the standards that Dickey set and the caliber of the speakers during my senior year. I was three-two, so my senior year was in the medical school. But we were required to take Great Issues, and we had just an array of fascinating dynamic speakers: Secretary of State Dean Acheson, Robert Frost, the editor of the *London Times,* Nelson [A.] Rockefeller ['30], Walter Reuther.

And the nice thing about it was that we had topics that would span one or two or three weeks and the speakers were relevant to the particular topics. I was particularly interested in the labor movement, and I remember Nelson Rockefeller addressed that from one perspective and Walter Reuther from another. And I was particularly interested in that, coming from Pittsburgh, Pennsylvania, so I was

rather steeped in the history of the labor movement in the mining and steel business. And it was extraordinary.

One of the most extraordinary things was the interaction with the speakers. In the Great Issues course, the distinguished visitors would speak on a topic on Monday evening, and we would all be required to go. This was not an optional course for seniors. Then the following morning, in 105 Dartmouth Hall, we would have a question and answer session. Would you like me to give you an example of a stimulating question and answer?

DAILY: Sure.

STRICKLER: The one I particularly remember was Dean Acheson, who was then the Secretary of State. This was either the fall of '49 or the spring of 1950. On Tuesday morning, during the question and answer session, one of my classmates asked the secretary of state the following question. And I'm paraphrasing, obviously. But he said, Mr. Secretary, I read in the *New York Times* this morning that the United States has lost another military airplane over Poland or Lithuania – one of the Baltic countries. And he said, This is the third or fourth, whatever it was, fifth incident in the last X number of months. And the explanation is that our airplanes were off course. Is that the real story? Was our navigational system so bad? And Dean Acheson – this could never happen today – turned to the president of Dartmouth College, and he said, "John, I'm going to answer that question in a very straightforward way if you can assure me I will not be quoted in your college newspaper." And at that time, the president was able to say, "I can promise you that." (chuckles)

Now, I have to tell you that this was at a time in our history when we really thought the Americans – we were all good guys. We were the guys that gave candy bars to the kids. Our troops never engaged in atrocities. And the United States wasn't involved in international hanky-panky. I'm exaggerating for effect, but that was, by and large, the perception we had. And the secretary of state turned to us and said, "Gentlemen," – there were no women in the class, no women present – "I'm going to answer this question honestly. What I'm going to tell you is common knowledge in Washington and in Moscow. I just can't be quoted as secretary of state for saying this. We fly over Russian territory all the time to check out various things, including the status of their radar systems, and they shot us down." And our class

gasped. Today you wouldn't think twice about that. It's commonplace. It was not commonplace then.

That may be the most dramatic experience with Great Issues, but that's the kind of experience we had, very candid discussions with leading figures of the world, who were very open with us. People like Robert Frost telling us what they really thought about stultified college education. So it was an exciting experience.

The other experience in Great Issues, which I think was one of the best educational exercises I've ever done, was the project that we all had to do, and that was to pick a topic and follow it in the media for several weeks – and I've forgotten the exact time span – and then to write a critique of how this topic was handled in the media. We were assigned reading assignments. Again, the exact details I don't remember, but we were asked to follow this in either three or four newspapers. Well, let me back off and say there were a series of topics, and we had to select. It turned out at that time there was a steel strike in Pittsburgh. It was either a steel strike or a miners' strike, but it was in my hometown and the labor issue was interesting, so I picked that topic.

I followed it in the *New York Times*, which was prescribed. I think you could select either the *New York Times* or *Herald Tribune.* I've forgotten the details, but there were certain papers that were mandated. I picked the Times. We were asked to follow it in our local newspaper, the *Pittsburgh Press*, and then I followed it in *Christian Science Monitor* and maybe one other newspaper. Then we were asked to follow it in two of the weekly journals at the time. I remember *Time* magazine, and I think the other one was *Newsweek,* although I'm not sure when *Newsweek* began. Then we were asked to listen to the news commentators. Remember, this is pre-television. We followed three news commentators, fifteen-minute news broadcasts each night, and I think Lowell Thomas was one of them and Gabriel Heater. That was determined because we had to follow somebody who was to the left politically, one to the right, and then one who was somewhat in the center. It may have been H. V. Kaltenborn.

So for a period of several weeks we had to follow this in the media and then write a paper on how this topic was managed in the media and how, particularly, a newspaper with a particular political slant would emphasize their political slant in the newspaper, not only by the content of what they wrote but where they put it in the paper, the

bylines, and so forth. We had to focus, for example, on what they did with an AP or a UP release, which they could not alter by content, but they could place it in a position in the newspaper that was on the back page if it didn't agree with them. Then we also had to pay a lot of attention to the editorials. And you could see how a newspaper could manipulate the message they wanted to give to the public. Oh, by the way, *Manchester Union Leader,* I think, was one of the ones that I followed in. I know I did, because they were essentially anti-labor. I think that was one of the most meaningful educational exercises that I ever participated in because it really gave me a perception of how the media can influence (presentation of) the news. That was an extraordinary experience.

The bottom line is that I think the Great Issues course was truly an outstanding course at Dartmouth College. Dickey took personal interest in this course, and it was just, I guess, too difficult to sustain. But it was a great course.

DAILY: What are your recollections of John Dickey?

STRICKLER: My recollections of Dickey were very positive. When I was a student, Dickey was a presence at Dartmouth. He was an imposing figure. He sort of epitomized what most of us felt a Dartmouth president should be, in his plaid jacket and his dog and very personable with students. He greeted us all in his office and shook our hands. I think we got a matriculation certificate. Dickey was very popular with my classmates.

You also have to appreciate that my generation grew up with war. We were really very internationally oriented because of the war. In all of my section, most of the hundred and fifty who came in with us, most of us had been in the armies of occupation or done most of our tour immediately after the atomic bomb. One of my classmates in medical school had been a combat infantryman in some of the worst fighting in Europe. So we were very attuned to the world. And John Dickey, of course, had been the deputy secretary of state under Cordell Hull (I am not sure this is accurate), had participated actively in the formation of the United Nations and the San Francisco Conference [April-May 1945]. And Dickey preached to us the importance of world affairs and international affairs and that we were part of global community. That was a strong message that resonated with us, I think more so than probably a decade later at Dartmouth.

So Dickey was pretty much of an idol, I think, to my class and particularly the class of '50. They revered Dickey. One of my classmates, Sandy McCulloch, [Norman E. “Sandy” McCulloch, Jr. '50], kind of reflects this. He, of course, has been a major supporter of the Dickey Center.

It's interesting that Dickey, at that time, outside of Dartmouth, was regarded as a leftist politically. The "pinko president of Dartmouth." I think it was Bertie McCormack, *Chicago Herald Tribune*, referred to him as that "pinko president of Dartmouth," and he was regarded as being very, very liberal. The irony of this – when I came back in 1967 to the medical school, Dickey was still president and was viewed by students as a conservative. The tragedy that I witnessed was the perception of Dickey at that time was that he was an ultra-conservative, a rightist, kind of out of touch with the times, and was besieged, of course, by the world events at that time – Vietnam, and so forth. Here I saw this man twenty-five years later, this giant, this icon, liberal, worldly, being vilified in the college newspaper by students. I got to know John a little bit at that time because I was associate dean of the medical school, and it was sad, it was rather tragic. It wasn't so much that Dickey had changed; the times had changed around him. One of the messages that came through to me that influenced my own thinking is that probably twenty-five years – or whatever his exact length of time in the office – is too long and that probably academic administrators should turn over somewhat sooner than that. That certainly impacted my own thinking, and I know it was also the thinking of John [G.] Kemeny ['22A], who was also one of my other heroes.

You probably know that since my deanship, I have gotten heavily involved in international work. People have often asked me why, and I say, essentially, for two reasons. One is I was being brought up in World War II and my father having been a marine in World War I, I learned a lot about world events during my childhood and was very attuned internationally because of, unfortunately, wars. Then having served in the Maritime Service and having been up and down the coast of South America before I came to college, having witnessed the development of the United Nations, and having all of that reinforced by Dickey's interest in the world instilled me with an interest and an appreciation for world affairs and cultures outside of the United States, which is sort of the background, if you will, why I, after my deanship, became involved in international affairs. So that's a long answer to your question.

DAILY: It's good to know. I wanted to circle around to two things. One is, What attracted you to medicine? And then particularly to go on to Cornell for med school?

STRICKLER: Well, first of all, most of my life I would answer that question saying I really don't know why. As far back as I can remember, I always wanted to be a physician. The more I think and thought about it, though, the more I realize that a major factor must have been the death of my sister, who was a twin. My brother and sister were born when I was about four years old, and my sister had a congenital malformation. It was actually an atresia of the common bile duct. In other words, she didn't have a common bile duct. She died of jaundice at age three months. And I can remember as a four-year-old one of my vivid childhood memories was watching this little sister wither away and turn yellow and the anguish of my parents as they were losing their child and then the anguish of my mother and going to the hospital with them when they'd take my sister. I suspect that this was a major factor.

Then all during my boyhood, I revered our family physician, a general practitioner who made house calls.

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

STRICKLER: Not only for positive reasons, I think for negative reasons. I always liked the biological sciences, and I always liked chemistry. This subject material in school, I think, furthered my interest in medicine.

But I also decided I didn't want to go into the corporate world. My father was a rather successful sales engineer, eventually vice president of his company. And my grandfather was a metallurgist in a steel mill. I later on worked in a steel mill, I was in and out of steel mills, I went down into coal mines. And the whole corporate world did not appeal to me. I think one of the things I wanted to do was to go into a profession where I was relatively independent, and medicine at that time *was*, and I envisioned myself as a private practitioner. So I think that there were positive reasons for that decision and negative reasons.

DAILY: And you chose Cornell for med school after you finished the two-year program here.

STRICKLER: Yep. I'm one of the rare individuals who actually turned down an opportunity to go to Harvard Medical School.

DAILY: Okay. Why was that?

STRICKLER: At that time the transfer from Dartmouth Medical School to another medical school to complete the requirements for M.D. was a very simple process as compared to later on. Essentially, it consisted of a chat with the dean, the dean telling you where you stood academically – not in detail – and then having a dialogue. Then when you reached consensus, he would pick up the phone – not at that meeting – and talk with the appropriate person at the other medical school, and your acceptance would be arranged over the phone in a personal way by phone conversation. It was very informal.

And the fact of the matter is that most of the students at that time went to a small number of schools, Harvard taking most of the students. At that time they took about half of our class, I think, or maybe just a little more. Then Penn, Cornell, Columbia, McGill were the other schools to which most of our other students went. And Dean Syvertsen [Rolf C. Syvertsen '18] said to me early on, "Jim, you're the top of the class and I can get you into any school that you want to go to." I had listed Harvard and Cornell and Columbia, and so forth. And I was not… First of all, I didn't like Boston. It was not as dirty as Pittsburgh, but it was not a very attractive city. And I loved New York. Because when I had been at King's Point in New York, I would spend weekends in Manhattan, and I really liked New York. Secondly, I had given blood when I was in the Maritime at New York [Weill] Hospital Cornell [Medical Center], and I was very taken with the hospital complex there. It's a very attractive complex.

But the real decision was made when we were discussing the pros and cons of Cornell versus Harvard and Dean Syvertsen said to me, "Jim, where's that pretty young fiancée of yours live?" I said, "Pittsburgh, Pennsylvania." My wife at that time was at the University of Pittsburgh. He said, "You know, New York's a lot closer to Pittsburgh than Boston is." I said, "Dean Syvertsen, you've made my decision." (laughs) And I never regretted it.

DAILY: Medical school for Cornell is actually down in the city. Is that correct?

STRICKLER: It's actually in Manhattan on the east side, 68th Street. It had a very nice physical plant and a relatively new hospital. It was actually built

in 1932, but compared to the Bellevues and some of the old Boston hospitals, it was a very attractive place in a nice part of New York.

DAILY: Now I want to kind of jump ahead to bridge a time period here. What do you think, during medical school and the early years of your medical practice, prepared you and led you toward coming back to Dartmouth and particularly to go into administration?

STRICKLER: Well, there were several factors. First of all, I love the academic milieu, and like most students of my generation, it never had dawned on me – I mean, my intent was to practice medicine and be a practicing physician somewhere. But as I became enmeshed, particularly at Cornell, which was the best educational experience I've ever had, in my junior and senior year of residency training with a *wonderful* faculty – a very, very warm school, particularly for a transfer student – I really thrived in the academic milieu. I loved the dialogue, the debate about patient care. I loved the interaction with patients.

I also, at the same time, was skeptical about the process of medical education. I'm going to be very candid with you about the medical education at Dartmouth Medical School at that time. Dartmouth Medical School at that time was at its nadir, and several of the more charismatic professors had retired. It wasn't as good a school as it was in the mid-forties and late thirties, in terms of teaching. Whereas, Dartmouth College undergraduate education had been outstanding, I was very disappointed in my first year of medical school. Not so much the second year when we began to get into the more clinical disciplines and some of the members of the Hitchcock Clinic taught us physical diagnosis, and so forth. But my first year medical education here was very disappointing.

Then when I went to Cornell, I was exhilarated by the teaching at Cornell and dismayed to learn how much better their first two years had been than my first two years. Not that I was all that far behind; I really probably wasn't in many ways. But they'd had a much more enjoyable experience in a much more structured first couple years. So that planted the seeds in me of discontent, really, if you will, about medical education.

Then as I became progressively involved during my residency training, I wound up doing a lot of teaching because I wound up as an assistant chief resident and chief resident, and I had to do a lot of teaching of house staff. Then I guess I acquired a pretty decent

reputation. And the nursing faculty at Cornell had a baccalaureate nursing program at that time. Actually, they also lead into a master's degree. I got asked by the deans of the nursing school to teach students, so I became interested in teaching.

After my residency, I took postdoctoral training in the department of physiology, and it turned out to be one of the most prestigious physiology departments in the country and a giant for the head of the department. Probably – well, in fact, at that time, it was regarded as the best teaching department – not only research, but the best teaching department in the basic sciences in the medical school, and I contrasted this to my physiology at Dartmouth and said, "Oh, my God!"

So all of this whetted my appetite for medical education and I sort of became iconoclastic and said, "We can do a lot better than we're doing." So I had that seed there.

Then, without going into a lot of details, I was doing basic research on kidney physiology and I sort of got caught in a blind loop where I was working with some really outstanding physiologists and realized that to continue in this field I would have to essentially become a biophysicist or a biochemist if I was going to stay at the cutting edge. And I really would have to give up a lot of clinical medicine, which I realized I didn't want to do.

Now, at this same juncture, the financial realities of the world hit me. I was now a young assistant professor and I was making thirteen thousand dollars a year in Manhattan. Even with inflation and so forth, that was still a very low salary, and one month I couldn't meet my bills.

Finally all of this all came together in about 1964 or '65, and I decided I just had to go into the practice of medicine. I was invited by two of my classmates to join their practice on Park Avenue. Their senior partner had died, and I had made a tentative decision to join them. I went in to my boss, who was then the chairman of the department of medicine, [E.] Hugh Luckey, and said, "Hugh, I've come to a decision that I want to discuss with you." I went through all of this and said, "I really feel I've got to go in the practice of medicine." He said, "Well, Jim, I've encouraged you all along to stay in academics, and I understand your problem." He said, "Now, what's not known yet is that I am going to be leaving this position in a few months and

become the first president of the Cornell Medical Center. We're going to develop a whole new administrative structure and try to develop liaison with Memorial, which is part of the Cornell system, and Rockefeller, and I really would like to have you join me in this and help conceptualize the design and work with me on this. And I'll double your salary." I said, "Hugh, every man has his price and right now mine is money." So I went with Hugh half time.

Then the chairman of the department asked me to take over the teaching program for the third-year medical students and also to have a lot of responsibility with the residency. So once again I had a role in teaching and developing. I've had a couple students of mine, [Anthony S.] Tony Fauci at NIH – you may have seen him on television a lot during the anthrax scare. Actually, he would now be the director of NIH if it weren't for his stand on abortion. And I had Robert Gallo also in that group. Worked with really exciting people, both at the faculty and the student level.

So after a couple years in that position, which was not a long-term position at the Cornell Medical Center, it was a start-up position to help this – I went to a conference on medical education at National Board of Medical Examiners, and I ran into Phil Nice [Philip O. Nice], who was the associate dean at Dartmouth Medical School at that time and had been a teacher of mine when I was at Dartmouth. He taught parasitology. We got chatting during this conference, and he said that Harry [W.] Savage ['26], who was what was then titled the secretary of the medical school – he was de facto associate dean for student affairs – was retiring and would be replaced by the new dean, Carleton Chapman [Carleton B. Chapman], and would I be interested. To make a long story short, that's what happened.

A lot of things came together. I realized that it was going to be very difficult to raise a family in that area. I had moved to the suburbs, and I was commuting. I still wasn't being paid a lot of money, and I had five kids to educate. And Dartmouth had a wonderful benefit package to help educate the children. And because the school was going to a degree program, I was persuaded to come to Dartmouth Medical School. That's the major reason I came.

There were a lot of factors in New York and Cornell that were pushing me in this direction, but the fundamental reason is that I was very much taken with Carl Chapman, who had just been named the dean of Dartmouth Medical School, and I was very much taken with the

opportunity to come and help develop the degree program and the clinical curriculum, and that was the major attraction. If it hadn't been for that, I would never have come back to Hanover, New Hampshire. And I thought it would be a wonderful place to raise my family. So it was a career opportunity plus the right move for my family, and I certainly have never regretted that.

Concurrently, Tom Almy [Thomas P. Almy], who just died a few months ago, came to Dartmouth as the chair of medicine, really the first full-time chair of medicine in the new program, to help develop this. Tom had been a mentor of mine, a professor, and a friend at Cornell, and we more or less made the decision together. He would come as chairman of medicine; I would come as the associate dean for academic affairs.

DAILY: Compare when you left Dartmouth Medical School in '51 to when you came back in '55.

STRICKLER: Well, that was another factor in my decision. When I left Dartmouth Medical School, it was at its nadir. And that term was used to me by Marsh Tenney [S. Marsh Tenney '44 DMS '44]. Marsh Tenney had actually been a postdoctoral fellow in the department of physiology when I was a first year medical student. By the way, Marsh had gone to Cornell too. He transferred to Cornell and then to Rochester. Marsh and I used to talk about the medical school back in the days when I was a medical student and he was postdoctoral fellow. We both agreed that the school was at its nadir. It was at its nadir; and yet, ironically, because, frankly, Dartmouth Medical School attracted very good students, we all did pretty well when we transferred. That says something about the caliber of the students, but it also says something about medical education in the first two years of medical school. It's not a one-on-one connection with your training in your later years, and it does not prognosticate your effectiveness as a physician. But that's a whole other story.

When I came back, Marsh Tenney had done an outstanding job by that time of refounding the school. It was night and day contrast. I mean, Marsh was a giant. When I came back, I knew that the basic science departments at the Dartmouth Medical School were really first-class, particularly in physiology and pathology. Kurt Benirschke was a leader and Marsh was a giant in his field. And that reputation had gotten around. So that certainly was a factor in my coming back as well, knowing that we would build our clinical departments from a

very strong basic science base. Although when I was a student, Marsh and I weren't close, but we remembered each other, and he was still a very strong presence in the school and was the chairman of physiology, and he encouraged me to come back as well. So it was a combination. There was Chapman and Tenney.

And then a lot of the better faculty that I had as an undergraduate were members of the Hitchcock Clinic. I remember people who taught me the introduction to medicine and my physical diagnosis instructor John Milne [‘37].

So there were a lot of positive things. But basically, it was the excitement of taking a two-year medical school and helping to move it to a degree program.

DAILY: Was there anybody at DMS when you got here in the mid-'50s who didn't want it to go to an MD program?

STRICKLER: Oh, sure.

DAILY: Can we talk about maybe not who but why?

STRICKLER: Yeah. Let me tell you why the decision was made to go to a degree program, because the history is distorted on this.

DAILY: Why don't we do that?

STRICKLER: The history's a little bit distorted on this, and I think it's important that people who really know what the history is set the record straight. By the way, a lot of the published history of Dartmouth Medical School has a lot of positive spin on it put on by development. Much of the history is written by development officers. I'm not criticizing. You have to do that too. You have to put your best foot forward when you're trying to raise money. But it wasn't quite as clean as all that.

There were several reasons why the Dartmouth Medical School had to either close or develop clinical programs. One of the unrecognized – at least by Dartmouth – driving forces, for the conversion of the school from a two-year school of basic medical science to a degree program was the Hitchcock Clinic. Do you know why? If you had to guess, why would you say?

DAILY: Well, I've done a little bit of reading. Now I'm trying to pull it out. I'm not going to offer an answer on that one. (laughs)

STRICKLER: You have to remember that physicians who came to the Hitchcock Clinic were individuals – and I do not mean this critically at all – were people who had opted out of academic medicine. They were people who, like most graduates of medical schools, decided to practice medicine. The slight exception to that being, some of the clinical people did teach physical diagnosis, and so forth, which they enjoyed. But their career was the practice of medicine, and their governance structure was the Hitchcock Clinic, which was a group practice. So most of them were not instinctively inclined to a career in academic medicine. Most of them were not pressing to move to a degree program, which required the building of academic clinical departments.

The major factor was that the free standing internship had been abolished. Do you know what I mean? The free standing internship?

DAILY: No.

STRICKLER: This must have taken place in the '60s. There were many internships in the United States that were run by hospitals and not affiliated tightly with a medical school. Cooperstown, New York, was one of them, although it did have some affiliation with Columbia. And Dartmouth Hitchcock. Hitchcock Clinic and the hospital ran an internship that was not affiliated with a medical school that had academic clinical departments.

So one of the things that began to happen is that it became increasingly difficult for the Hitchcock Clinic to recruit. The Hitchcock Clinic also had, by this time, developed residency programs in several of the specialties – internal medicine and surgery – and they were having progressive difficulty maintaining their accreditation in the absence of academic clinical departments. Tom Almy and I researched the accreditation status of the school before we came. Tom was very active in the American College of Physicians. And we learned that the residency program in medicine was not going to be either approved or would be put on probation. We also learned that the same was true of the program in surgery. So the Hitchcock Hospital and Hitchcock Clinic were faced with a probability that they would not be able to sustain post-graduate training without an

affiliation with a medical school academic clinical departments. This was a major factor in the Hitchcock Clinic's decision.

I'll give you one anecdote on this, because after I arrived and as the medical school got into the act, so to speak, in the clinical departments, some of the Hitchcock Clinic members rebelled against this, because all of a sudden, the people in the clinical departments, they could see, were going to be subjected to academic standards and this was rather threatening to some of them. I was sitting around with two of them one evening at the faculty club, and we were drinking Jack Daniels. One of them said to me – I won't name names – but said to me, "Jim, we don't really need a medical school here and have people coming in and telling us what to do." I said, "Well," so-and-so, "let's cut through the baloney, and I'll tell you why you want a medical school." I said, "You don't want to get up at night and go in there when a resident physician can be first on call, and without an academic department of surgery, that's what's going to happen." He pushed the bottle of Jack Daniels over and says, "You win." (chuckles)

So that was a major factor. It's interesting, most people don't understand that.

DAILY: It doesn't show up anywhere.

STRICKLER: It doesn't show up. And I don't think the Dartmouth trustees ever understood this. Now, the interesting thing about this is that the Hitchcock Clinic members – at that time, many of the older members had either been persuaded this is what had to be done or they were not actively opposed to it because they were going to be retiring within the next five or six years. They were relatively supportive. And one of the outstanding supporters was Jack Bowler [John P. “Jack” '15], who was a giant. He had been a founder of the Hitchcock Clinic and had served as its president for many years. He was a little man who was a giant and very bright, and he saw the need to go to academic clinical programs. I got to know Jack quite well, and he was absolutely supportive because he understood why we had to develop academic clinical departments. He also told me privately, he said, "Jim, Hitchcock Clinic is going to have to change profoundly, and many of them aren't going to like it."

But the older guard, who happened to be teachers of mine in medical school that I became close to, were either ambivalent or they weren't

active opponents. The group in the clinic that gave us the most difficulty was the mid-career people who kind of felt they'd been sandbagged. They had opted out of academic medicine. And as I say, I don't mean that critically. Most physicians opt out of academic medicine. And all of a sudden they're finding themselves engulfed by academicians in an area where they wanted to live and raise their children and didn't want to move. And some of them became really quite hostile to the medical school.

Another group that was ambivalent were some of the basic medical scientists, because in their own way, they reigned supreme in the medical school in the absence of clinical departments. Some of them realistically could see that there would be a diversion of resources – Dartmouth Medical School is not a wealthy school – and that more and more of the resources would go to clinical departments, particularly if you're going to build clinical departments. So some of them were reluctant.

Secondly, they all knew that in academic medical centers, the political center of power lies, in large measure, in the clinical departments. And it's the chairs of medicine and the chairs of surgery in conjunction with a prestigious teaching hospital that really become *very* influential politically. So there was opposition there too. It was not a slam-dunk.

DAILY: Why would folks mid-career from the clinic oppose, beyond just the difference between academic medicine and practice?

STRICKLER: Well, the model that the Hitchcock Clinic tried to impose was a model in which the chairs of clinical departments and the other academic people who spent a lot of their time in research, functioned really organizationally in a parallel way to the Hitchcock Clinic. And they did not really perceive that the chair in medicine would also be the chair of the practice group in medicine. They tried to impose that model and were very reluctant to have the chairs be the chairs with equal responsibility for patient care, teaching, and research. And that has been a major problem in the governance of this institution until this day.

DAILY: To have the chair responsible for all of those three areas.

STRICKLER: Some of our early chairman were bruised and battered by this, and the clinic really did not accept that role for them. And to be fair to the clinic, some of the people we got in as chairs were not realistic about

their responsibilities chairing a practice group. I mean, none of this is black and white. And we had a couple of chairs who were idealistic, who were great teachers, who were wonderful with the residents program but really didn't understand the hard, cold realities of the practice of medicine and balancing the budget. So it's been a tough evolution.

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

STRICKLER: Another reason for the development of the Dartmouth MD program is that it became increasingly difficult to transfer students to other medical schools. One of the reasons that Dartmouth was able to transfer students to other medical schools was because the capacity to educate students in the clinical years was much greater in urban medical schools than their capacity to educate students in the basic medical sciences. These were huge hospital complexes: New York Hospital, twelve hundred beds; with Memorial Hospital, a thousand beds; with Mass General in Boston. They had this tremendously large clinical faculty, so they could accommodate a larger number of students in their clinical years of training than in the preclinical years.

At that time there was also perceived to be a doctor shortage in the United States so that the federal government, through a variety of means, was subsidizing medical schools, including capitation grants for medical students. Each school got a capitation program. So the medical schools had incentive to expand in their clinical years. Harvard, at one point, was taking – I've forgotten – twenty-two, twenty-three students a year from Dartmouth.

Then one of the things that happened is that the Association of American Medical Colleges and the AMA and the accreditation bodies became increasingly rigid about these transfer programs and, at one point, mandated that any two-year school would have to develop an agreement with a four-year school, some sort of formal agreement, to be able to continue to function. A much tighter liaison at a four-year school.

Then the real blow came when Harvard decided that it wanted to develop a new track, a track that was more sophisticated in bioscience, and they decided to do this in conjunction with MIT. They developed the MIT-Harvard track, where the students took their preclinical work at MIT and the numbers were just about the same as

the numbers they would take from Dartmouth. That was the coup de grace.

By the same token, the other medical schools were tougher to get into. Cornell, where I graduated, had been all through residency, and had been on the faculty, knew all the people down there, I was having trouble transferring students to Cornell. So the transfer problem became very difficult. One of our distinguished basic scientists, who was not enthusiastic about moving to a degree program, would say to me, "You people are just exaggerating this transfer problem. It's really not as bad as all that." And I would say to him, "I'm the guy responsible for transferring students. You don't know what you're talking about. It's becoming very difficult."

It also had implications for the quality of students because we were perceived, rightfully so, as the back door to Harvard. I certainly don't want this published in my lifetime, but we got an academically higher caliber student at Dartmouth Medical School during those years when Harvard was taking half of the class than we did immediately after we went to the degree program. There was a drop-off in the academic caliber qualifications. We've never publicized that. But those of us who were there knew that was happening. So it was a complex process.

DAILY: What were your responsibilities as associate dean? What did they entail?

STRICKLER: There were two perceptions of my role. I was recruited by Carleton Chapman to essentially become the dean of academic affairs and to help him build the academic clinical departments and to help develop the curriculum for medical students and to plan the future of the school. That was the role, which I actually did fulfill and we can talk a little bit more about that. But I replaced Harry Savage, who had been the secretary of the school, who actually functioned as an associate dean, so Chapman gave me the title of associate dean and not secretary. Harry Savage's principle responsibilities had been student affairs and admissions. And the perception of a lot of other people in the dean's office was I was taking over Harry Savage's job and that was my primary responsibility. There was a little bit of conflict there. In fact, I did serve on the admissions committee and did work actively, and I did do student affairs, but not to the extent that Harry Savage did. In the eyes of the dean, they were of secondary importance and he felt that Phil Nice and others should manage those responsibilities.

The other major responsibility I had was to transfer students to the four-year schools until we had fully implemented the degree program, and that took a lot of my time during those years. So my principal responsibilities evolved as the dean for academic planning, if you will, and the transfer of students. My charge, really, was to develop the three-year curriculum.

DAILY: Okay. Let's talk about that. Why three years rather than four?

STRICKLER: Okay. The real reasons? I mean, there are reasons that were public and there are the underlying real reasons. There are two issues here. One is the need to go to a degree program, and the need was really compelling from the standpoint of residency programs in the hospital, and it was compelling because of the changing scene about transferring students. So those were the driving forces. Now, I have to be fair to those individuals on the faculty – and there were some – who really wanted to be part of a four-year medical school and a degree program. There were imaginative, creative people, both in the clinic – Jack Bowler being one of them – and others who really were very enthusiastic about this. Your question again?

DAILY: The reason to go with a three-year program rather than a four-year.

STRICKLER: Okay. The first reason was, there were compelling reasons, we felt, for the school move to a degree program. Now, why a three versus a four? Well, there was some sentiment in various places in the country that medical education was too long and somewhat cumbersome. This was not a predominant view, but it was a view shared by Carl Chapman and articulated and espoused by Chapman. Carleton became very influential in the council of deans and actually chaired the council of deans and, I think, persuaded some people that this was a good idea.

Carleton was an iconoclast in medical education. He had done his preclinical work at Oxford and had transferred back to Harvard and had a different educational experience. He really felt American medical education was too long and that it could be streamlined without a compromise in quality. That was a firm conviction on his part. I think Carleton, who was one of the most intelligent individuals I've ever known, also knew that the conversion to a degree program was going to be very expensive and cost Dartmouth College a lot of money. I think he really knew that it would be easier to sell an

accelerated three-year program than a four-year program that would cost the school more money. Carleton also felt that a lot of this could be accomplished by going year-round, and there was a more efficient way of doing things.

It was very clear that my charge as academic dean was to develop a three-year curriculum. The driving force, really, was Carleton Chapman, who was a zealot in this. By the way, Carleton Chapman, I know, was controversial when he left; but in my view, Carleton Chapman was one of the most creative, brilliant, dynamic individuals that I've ever worked with. His views on medical education, I think, in large measure, were right. I think that he oversold the three-year curriculum, and I think he did, in some measure, for very practical reasons. But his views about teaching, his views about the role of basic science, his view about the role of the medical school in rural New England were extremely creative, and I'll come back to that in a moment. So I emerged a devotee of Carleton Chapman. I think that Carleton Chapman's reputation is far too tarnished, for reasons that I can get into, and that he was a dynamic leader.

One of the problems was that Carleton could be a very difficult person. I happened to get along with him better than most. I had a break point with him where we got into a spat over something. I was his associate dean, and I said, "Carleton, you're the most difficult son of a bitch I've ever worked for." And he looked at me and he smiled, and he said, "That's probably right, Jimmy, but I think you and I can work it out." And we did. And he eventually became my patient. After the deanship, when I retired, we became good friends.

I want to set the record straight. This man was an extraordinary person. He had a terrible temper. I remember one time talking to him about his relations with the faculty, which were not optimal. And he said, "What's the problem?" After a twenty-four hour hiatus, I went back to him and said, "Carl, I'll tell you what the problem is." I said, "You're very, very intelligent and everybody knows that." Parenthetically, one of our senior faculty had referred to him as being "dangerously intelligent." I said, "You're *very* intelligent and everybody recognizes that. Secondly, you've got a terrible temper. And that combination intimidates people. You don't get the feedback that you ought to get." And he said to me once again, "Jimmy, it's been a problem all my life." And he said, "I guess that they'll either have to put up with it or I'll have to leave one of these days."

And that is true. That was his weak link. All of us have strengths and weaknesses. That was Carleton's weak link. He would get intemperate at times in advisory board meetings. I've actually seen him turn to one of our chairmen and say, "Shut up! Just shut up. I've had enough of that." Well, you can't – most of us would like to do that, but Carleton did it. And it got him into difficulty.

DAILY: Let's circle back to what, specifically, were some of his views about medical education that were iconoclastic and that you thought were positive.

STRICKLER: Well, I think, for example, let's take basic science medical education. Carleton was a distinguished cardiac physiologist, and he well knew the importance of the basic medical sciences. Carleton was not anti basic science intellectually. He just thought that the teaching of basic science was archaic and that the students were sitting in the classroom, essentially, seven or eight hours a day being spoon fed by the lecture method and that that was horrendous. He was programmed, in large measure, by his experience at Oxford.

DAILY: Okay. How was that different from here?

STRICKLER: Well, essentially, it was less didactic and more library and more independent study by students and much more freedom. He basically felt that lectures should be cut in half and that we should have a much more imaginative, flexible, experience, with more onus being put on the student. And I agree with that. This sitting in class for seven or eight hours a day being lectured at was something that many of us disliked. This was very threatening to a lot of faculty, because they would perceive this as a diminution of their role and as a consequence, a potential diminution of their budget. Eventually, we did get our faculty to agree through this academic planning committee that I chaired. But it was not an easy process.

So Carleton's model was really the Oxford model, the English model of medical education. And I basically agreed with that. I felt that it should be much more flexible, that more onus should be put on the student, that the student should spend more time in the library reading and not listening to lectures, that the interaction with faculty should be more seminar type and interactive discussion.

By the way, this is largely what's taken place over the years in medical education and many other things. For example, testing. Faculties in

medical schools at that time were – well, they were almost anti-intellectual about testing in that there was, by this time, a substantial body of knowledge of the science of testing. I had been to a number of sessions sponsored by the National Board of Medical Examiners, and I realized that the testing procedures were archaic, antiquated, and probably unfair. Let's take a multiple choice examination. I mean, that's become a science. I don't want to get off on the pros and cons of multiple choice examinations. But if you're going to give multiple choice examinations, you've got to give an examination that has been validated. There's a whole science of testing. Some of our best faculty members spurned that, and their attitude was, We've been writing multiple choice examinations all our professional careers. We don't need to have anybody tell us how to do that. And I knew that they were just dead wrong.

One of the things I tried to do was get somebody with a background in education to join the faculty. There was a wonderful head of medical education at either UCLA or USC by the name of Steve Abrahams, and he would speak to the council of deans on medical education. He was very impressive, colorful, with a great sense of humor. Steve Abrahams, in these other sessions that I went to, convinced me that the time had come for medical educators to think more objectively about the educational process. So I tried to get one of Steve Abrahams' protégés to come onto the faculty of Dartmouth Medical School. I brought this protégé, who happened to be at Pittsburgh at the time, to school for a visit, with Carleton Chapman's approval, and I brought him before the academic planning committee that I chaired. Prior to his coming, the members of the committee said, What are you bringing this guy here for? We don't need somebody like that. And he came and he charmed the academic planning committee, and they voted unanimously to try to bring him aboard as a faculty member. It then went to the dean's advisory board. I was not the dean, I was associate dean. And Chapman was supportive of the idea. The departmental chairman nixed it. He said, "We don't need somebody in here. We're educators. We've been doing this all our lives."

Now, at the same time in the school Hale Ham, [Thomas Hale Ham '27] – I don't know whether you know that name. Thomas Hale Ham was a Dartmouth alum – I'm not sure whether he was a medical school alum as well – who then, I think, went on to Harvard and eventually became a distinguished hematologist and wrote one of the standard texts at Harvard and then moved on to Case Western Reserve and was instrumental in totally revamping the Case Western

Reserve curriculum in medical education. He was a *real* iconoclast. The Case Western Reserve curriculum was one of the great innovations. Hale retired to Hanover, and Hale and I and Tom Almy became good friends. So from various quarters I was getting feedback about the educational process, and I became as iconoclastic as Chapman did.

Carl and I were largely in sync on this. I'm pleased to say, many of the things that we instituted and started have persisted to this day. And of course, as is always the case in history, the people who generated this frequently don't get the credit for it. But that's the way the world is and I'm not paranoid about that.

DAILY: I was reading about this. Setting up the curriculum to meet health care needs in rural New England, what did that look like? Why would that be different from, say, Harvard?

[tape off, then resumes]

STRICKLER: – regional health care system, if you will. I think this is a very important chapter in the history of the school. It's interesting if you go back to the founding of the Hitchcock Clinic, Jack Bowler and others, that they had a concept of relating the Hitchcock Clinic to the regional care system that we are embodying today. They, in the first couple decades, were very, in Jack Bowler's words, "centrifugally oriented and not centripetally oriented." I can give you a couple examples. For example, the chairman of pathology when I was a student, Ralph Miller [Ralph E. Miller '24] – legendary Ralph Miller, who, unfortunately, died in that terrible plane crash – did autopsies all over the state. He would fly and drive to various regional hospitals. That was one example.

The pathology department, in particular, would help other hospitals set up laboratory procedures, and so forth. They were very attuned to the needs of the practicing physicians outside and, in fact, led to some controversies inside because sometimes Bowler would say to them, "Look, when this guy wants you to do something for him, I want you to jump." I know of a couple instances where he jumped on a radiologist for not being sensitive enough or cooperative with physicians outside of Hanover. Now, Jack Bowler was also looking at it not only from a humanistic standpoint but in terms of business for the Hitchcock Clinic, because we were the referral center.

And that was true when I was a student. When I came back in '67, the clinic leadership really were more taking the position that our business was here in Hanover and we were a magnet and we would attract patients and serve the physicians, be much more centripetally oriented. I remember the president of the clinic saying this. And to jump ahead, we've come around full circle philosophically.

Now, about this time, American medicine in general was beginning to think more regionally. Even in New York there was talk about regionalization of medical care. There was talk about creating a more efficient system of medical care. This was driven by rising concerns about costs. In fact, there was developed a program by Lyndon Johnson called regional medical programs, federally funded. And Carl Chapman had been one of the architects of the national legislation called regional medical programs. This was a federal program that divided the country into regions, which is why it was called RMP.

Originally, all of New England was to be one region. Then the politics came to bear and Vermont peeled off and became its own regional medical program; Maine peeled off and became its own regional medical program; and Connecticut, I think, went its own way. But New Hampshire, Vermont, and Massachusetts became the regional medical program.

Where I got to know Jack Bowler, who had retired as the president of the clinic, was when Carl Chapman asked him to be the medical school's representative to regional medical programs. And I wound up traveling with Jack Bowler to a lot of meetings in Massachusetts and became very close to him and eventually a good friend and a pallbearer at his funeral.

So what I'm saying is that there was a growing national interest in regionalization of medical care and, as an example, regional medical programs.

Now, in developing the clinical curriculum, we had to deal with certain practical realities. One of the practical realities was we had to teach our students what was then called public health, and they had to pass a board examination in public health. I was chairman of the academic planning committee, and we were well along the way to implementing academic departments in medicine and surgery, maternal and child health, as we called it then, and pediatrics. But we really hadn't come to grips with what we do about quote public health unquote. In those

days, we were in a position to be much more directive because we didn't have a large academic clinical faculty, and Tom Almy and Chapman and I and a few others made a lot of the decisions. We began to think out of the box, and we said, "the department of public health, first of all, we don't like that name," and we eventually came up with community medicine.

And this is where Chapman was very, very good. He felt that an academic medical center ought to relate much more effectively to the system of medical care in the region and that it would be easier to do this in a rural medical school than in an urban medical school where you had five or six other medical schools competing with each other, as in New York City and Boston. And they made this pretense about cooperating, but the fact of the matter, it was dog-eat-dog, who gets the biggest share of the marketplace. So we, in a vague way, had this vision about a different type of department of community medicine.

Ross McIntyre [O. Ross McIntyre '53 DMS '55], who was a very, very able professor of hematology – he was appointed as chair of the search committee. But Ross, for whom I have great admiration and respect, was a little slow getting this off the ground. One day I went into Chapman's office and said, "Carleton, we've got students coming in in a year and a half from now, and we haven't even started to recruit this chairman of community medicine, and we've got to get on it." And I walked out of the office as the chair of the search committee. (chuckles)

Then I said to myself, "What the hell is community medicine?" What I did was I did a literature search, and looked at what the departments of public health, or whatever else they called it, were doing in the country. I brought in a couple consultants. And I found that some departments of community medicine were just simply teaching epidemiology and infectious disease. One of the departments in Kansas was, as the chair of that department, who was our consultant described, the "conscience of the school" and they were into ethics and good medical practice, and so on. Another one in Kentucky that I visited, which at that time had quite a reputation as a creative, imaginative program.

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

STRICKLER: – in Kentucky, which I visited, and I remember finally winding up with the dean, asking him his views of this department. And he said, "Well,

our department of community medicine, it's not a discipline, it's a religion."

So at any rate, I came back with that garbled background. I'd done my homework, and I was beginning to have a vision about what this department should be. And one other factor came to bear, which was crucial, and that is that the Hitchcock Clinic and the then president of the clinic, Jerry Folley [Jarrett H. Folley], very rightfully said, "The Hitchcock Clinic does not have the capacity to provide outpatient experiences in all of the disciplines that are required in medical education," and particularly what we now call primary health care.

So the Hitchcock Clinic – and I do not criticize the clinic for this. They were absolutely right on. They said, "We can't handle the clerkships in primary health care. We don't have enough." So we decided that this should be the responsibility of the department of community medicine. And the clinic concurred with that.

So that's factored in now to our thinking about what kind of a department. Then our first chairman, Ken Johnson [Kenneth G. Johnson] came. Oh, yes, and then we had a great debate in our academic planning committee because our basic scientists saw this as being intellectually fuzzy, and this was more like sociology. We finally decided that there should be a scientific basis for this, and we decided this is where epidemiology should be, because it was appropriate. It also enhanced the credibility of the department with our more scientifically oriented faculty. Then we recruited Ken Johnson. And we decided that he would be responsible for primary care education, that the basic discipline would be epidemiology, that we would begin to look at systems of medical care, and eventually, without going into all the details, we expanded to include ethics.

Then Mike Zubkoff [Michael Zubkoff] came to me one day and said, "We've got this wonderful potential candidate by the name of Jack Wennberg [John E. Wennberg]." We recruited Jack Wennberg, and you know his reputation in the – you know about CECS [Center for the Evaluative Clinical Sciences]?

DAILY: No.

STRICKLER: I'll come to Wennberg in a moment. At any rate, Ken Johnson was here and got the department launched. He left when I became dean. One of the ironies of it – this is one anecdote I will tell with names – is

that Ken and I had become pretty good friends because I liked his imagination and his creativity. But one of his philosophies was to keep the dean in the dark. He joked about that. Chapman and Johnson had sort of a tenuous relationship and Chapman was very temperamental and authoritative, and Johnson was secretive and he'd also done the same with the dean at Cornell. When I became dean, I called him in and said, "Ken, I know your philosophy and I ain't about to be kept in the dark." And he said, "Well, maybe the time has come for me to move on." (chuckles) But he really launched the department conceptually and intellectually and deserves credit for that.

Then the next thing that happened, we recruited Mike Zubkoff, who has been here twenty-five years. The chair of the search committee, Peter [C.] Whybrow, a psychiatrist, chair of psychiatry, came in one day and said, "We've got our top candidates lined up and number one on the list is a health care economist. What do you think about having a health care economist as chair of community medicine?" And I said, "Peter, no way." I said, "Look, the political problems that we have with the Hitchcock Clinic are such that I can't have a non-M.D. running that department, particularly if we're responsible for primary care education. He says, "Well, would you at least take a look at him?" I said, "Yes." Mike came and I became his strongest supporter, and he's been there for twenty-five years and has done an outstanding job.

His department is now recognized as one of the very best departments of community medicine in the United States. I think last year their research funding was thirty to thirty-five million dollars. He recruited outstanding people, like Allen Dietrich and then Jack Wennberg, who built the whole CECS, Clinical Evaluative Science Program, which now essentially is a school within a school and has developed its own master's program, its Ph.D. program, and the MPH program. Just get their brochure sometime. It's put that department on the international map. I mean, Jack has done that. Mike recruited him, and I'm pleased to say that I supported Mike.

Then when Jack was about to leave and wanted tenure, we had a freeze on tenure, and I did battle with John Kemeny – not an easy person to battle, it was a friendly battle – and finally persuaded John to make an exception and give Jack tenure.

So I take great pride in the department and also playing a role in developing that department and Jack Wennberg. This is one of the reasons that I have an office in community medicine to this day and why Mike Zubkoff and I are close friends. As people say to me, "Jim, you're the patron saint of . . . " Actually, Bob McCollum [Robert W. McCollum] told me that. He said, "You're the patron saint of community medicine."

I would also say that Mike and I, after I recruited him, had some stormy sessions for several years, because Mike is the classical entrepreneur, pushes the envelope constantly, wanted more money all the time, wanted to expand beyond the school's resources capacity. So my role became reigning him in at times. Mike and I laugh about it today. It also, I think, illustrates a fundamental principle of management; namely, that by and large, as a leader of an organization, you're better off surrounding yourself with bright entrepreneurs than people who are not highly motivated. I'd much rather try to reign in an entrepreneur than deal with somebody who's apathetic.

The next thing that happened – and this is important historically – is that, as part of this, we developed this regional faculty and began to put our students in primary care all over New England. We've developed a very strong community-based faculty and have tied them in with what's called the "co-op," in which they participate in activities as faculty members, including research activities. There's a community-based group that does collaborative research in the community; we get our community faculty involved in teaching; we provide instruction in teaching; we help them develop computer capability and resources; and I think it's fair to say that Dartmouth has one of the strongest community-based faculty teaching programs in the United States. In fact, during the last accreditation review, I'm told that the deans from several prestigious schools said, "This department, in terms of community-based teaching, is one of the most creative and imaginative in the United States." And it really is.

We also did some other things, recognizing that – because I was raised in an urban area and I went to an urban medical school. And I realized that one of the advantages of Dartmouth is "place," as John Kemeny used to say. In terms of medical education, it's a disadvantage in the sense that we have a very homogeneous community. It's not racially diverse, and this has some negative

implications for medical education. This is one of the reasons we developed the clerkship in Tuba City [AZ].

DAILY: What's Tuba City?

STRICKLER: The Navajo reservation. We developed that as an elective experience initially, but it has now become a primary care experience where our students can do their primary care.

Then we developed a teaching program – this was not community medicine, although we did play a role in community medicine – in the Martin Luther King Medical Center in Los Angeles. We used to send students there for obstetrics and gynecology. A black Dartmouth alumnus ran that program.

So what I'm saying is, in effect, that outreach has been very much part of the core philosophy of the Dartmouth Medical School. And this was grafted on to a philosophy that had existed in the Hitchcock Clinic and now is a predominant philosophy of the entire medical center. If you listen to Jim Varnum [James W. Varnum '62] or Paul Gardent [Paul B. Gardent TU '76] in the hospital, they will tell you at great length about how this philosophy pertains to the regionalization of hospital care and how they have developed linkages with regional hospitals. So across the board, the whole medical center now has this concept, and I think it is one of Dartmouth's great strengths.

And I want to give a lot of credit – back to the beginning – conceptually, and nobody recognizes or acknowledges that Carl Chapman was one of the creative thinkers about a department in community medicine.

DAILY: That's where I wanted to go, back to Carleton Chapman. You say he was a controversial figure. I've read where he stated, when he left, in a letter to you, that while he was dean it was one of the worst periods of his life, basically. You touched a little bit upon it, but if we could go into that deeper, not so much to dig into personalities but where the battles lie in the medical school and –

STRICKLER: There were two problems that Carleton had. It was Marsh Tenney, actually, who once said to me, "The man is dangerously intelligent." Carleton got into progressive difficulty with the faculty because he was a change agent. I happened to agree with a lot of the changes he was trying to accomplish, as did a number of other key faculty; as did,

for example, Marsh Tenney, most of the time. But Carleton was intemperate, and he was not at all skilled in group dynamics. That's what really got him into difficulty with the faculty: a dynamic, creative, imaginative, iconoclastic change agent with a bad temper. He alienated a lot of people, intimidated a lot of people, and they reacted to that, number one.

Number two, philosophically, he and the other academic chairmen we recruited had a different vision and conception of the role of a medical school in the academic medical center. And we felt, and I'm in that camp, that the departmental chairs should be chairs across the board for teaching, research, and patient care and that the dean should play a very strong role in the recruiting and appointment of faculty across the board. So the second reason Carl got into difficulty is that he brought with him a concept of how an academic medical center should be organized and governed, which was the concept in most medical centers in the United States. It wasn't unique with Carleton. But it was very threatening to the Hitchcock Clinic. So that was the second reason he began to get into difficulty.

And on both of those issues, his views on medical education and his governance of the center, I was very much in Carl Chapman's camp. He and I shared the same views, as did Tom Almy and most of the other clinical chairmen. But they were also threatening because this was a change.

At the same time, the hospital board of governors had no concept of what an academic medical center was all about. And this is not a reflection on the caliber of the people. These essentially were small-time businessmen, good people, but they had absolutely no concept that we were trying to develop a medical center with a national, indeed someday international reputation. And this created lots of problems.

One little anecdote here is that there was a very distinguished professor from England. He was the head of the Radcliffe Infirmary at Oxford, which essentially meant he was the professor of medicine and chair at Oxford, and he was Regis Professor of Medicine. His name was [Sir] George Pickering. He had actually been here at the refounding of the medical school, the big ceremony that Marsh Tenney put on with a very distinguished panel. Pickering was one of the degree recipients at the time and fell in love with Hanover and kept coming back.

I got to know Pickering, and after I'd been dean a couple years, I went to Oxford to look at medical education there. Pickering by then had left the medical school and was the master of Pembroke College at Oxford. George Pickering and I were sitting around and he was talking to me about Hanover, and he said, "Oh, Jim, how are you faring with that hospital board of yours?" And I said, "Well, Sir George…" And he said, "Oh, stop the Sir George. That's pretentious." And I said, "Well, George, we're making progress. But frankly, most of these people have no concept of an academic medical center in a teaching hospital." I said, "We're making progress but it's slow." And I said, "A lot of our progress is going to come about through attrition of the board." And Pickering looked at me and he said, "Oh, just remember, where there's death, there's hope." (laughs) Tom Almy was with me at that meeting, and he said, "Don't you dare say that in Hanover." (laughs)

Now, let's get on to the other difficulty. The difficulty Carleton had that really got him into the most trouble and finally precipitated his exodus was the finances of the school. Something that you may have never heard before is that, if one wants to look analytically at the financial problems of the Dartmouth Medical School that evolved when we went to the degree program, and you wanted to fix blame, you'd start with the Dartmouth Board of Trustees. The Dartmouth Board of Trustees did not do due diligence. They did not commission when the decision was made during Carleton's deanship. What they should have done was to have somebody like Peat, Marwick & Mitchell or McKinsey or somebody, or the Association of American Colleges, come in and say, “We want to transform a school from an M.D. program in rural New England to a degree program. What are the implications for Dartmouth College and what is this going to cost us?” They didn't do that. It was not a sophisticated analysis.

I don't say this publicly. I'm a loyal Dartmouth alum. But people studying the history of the institution should know that. And a lot of this I understand. See, I had three members of the board as my classmates. Two of my classmates were on the board when I was dean. And I know that the focus of the trustees has been on arts and sciences and undergraduate education and that the Dartmouth trustees to this day don't think in university terms the way the Harvard Board of Overseers does. I think we're moving in that direction now. So a lot of this was attitudinal and traditional in the role of the Board of Trustees of Dartmouth. They did not do due diligence.

And they were persuaded to go to a degree program by Carl Chapman, in large measure, and by the circumstances of the transfer that I told you about, with the support of the Hitchcock Clinic. The clinic played a role in this transition that even the Dartmouth trustees did not realize. I once explained to John Kemeny why the Hitchcock Clinic went along with it, and he didn't understand it, the problems with the residency, and so forth. Then what happened is, we moved to a degree program, three-year versus four, I think, for economic reasons, because Carl Chapman was smart as a goose and he knew damn well that it would cost a lot more to go four years rather than three at that time.

Then a couple of things happened. We hit a bad period of inflation. There was a big oil crisis at that time, and all of a sudden, the cost side of the ledger skyrocketed – fuel costs, especially – and we went into a period of inflation. The second thing that happened is the federal government decided that we had enough doctors. The secretary of health at that time was a man by the name of Joseph Califano, and he announced at a meeting in New Orleans, some big medical meeting, that the United States' problem was not an insufficient number of physicians but a maldistribution of physicians. As a consequence of that, the federal government stopped capitating medical schools. What you did at that time, you got X-dollars for each student in a grant every year. I've forgotten what the numbers were. Somehow the number two hundred fifty, three hundred thousand dollars sticks in my mind. That's not much money today, but in those days, it was quite a bit.

So one of the things that happened is that poor fiscal planning, a real underestimate of what it would cost the school, coupled with change in federal funding policy to medical schools, plus inflation – this was before I became dean. This culminated then in a rather precipitous awareness of Dartmouth College trustees that the school was going to be running a one to a 1.2 million dollar deficit for the foreseeable future. And I think we had an endowment at that time in the range of three million dollars, two and a half, three million dollars. So I mean the proverbial hit the fan.

I became dean in '73 and this really hit the fan in the fall of 1972. The trustees and the president panicked, and what they decided to do was to appoint a committee to study the finances of the medical school and report to the trustees and to recommend, if possible, a long-term solution.

As this evolved, it became very clear there were trustees who really felt we should close the school. I'll get into that in a little bit. At any rate, what happened, I'm associate dean now, Chapman is dean. The president asked *me* to chair what was called the "Survey Committee" of the medical school. Do you have that report?

DAILY: I've looked at it.

STRICKLER: So they appointed a survey committee without the dean. I was the chair. Here I am the associate dean now. Marsh Tenney's on it, who is a real giant, who refounded the school, and there's a whole list. You have the list there. There were faculty members on it. It suffices to say there were faculty. Then the president of Dartmouth, John Kemeny, Bill Morton [William H. "Bill" Morton '32] from the trustees, and Monty DuVal [Merlin K. DuVal DMS '44], who was a Dartmouth Medical School alumnus who, when he was on the committee, was the secretary of health. This was before it was Health, Education and Welfare. He was the secretary of health and had been the founding dean in Arizona, was a professor of surgery, and a medical school roommate of Marsh Tenney's. And Elmer Pfefferkorn [Elmer G. Pfefferkorn] was on the committee and Ken Johnson and the trustee that I mentioned and Kemeny. I think that was pretty much it. Maybe Phil Nice was on it. I've forgotten. Anyway, the list is there.

And my charge was to analyze the finances of the school and to recommend to the board of trustees either to close the school or to recommend a financial solution, if you will. The committee was convened in the fall and I think we reported to the trustees in April. This was a very trying period for the school because during that period, it became apparent the financial situation was deteriorating, and it also became increasingly clear to Carl Chapman that the time had come for him to move on. You can just imagine yourself as dean of an institution, essentially the CEO, and having a committee appointed to oversee your financial management of the school; and your associate dean now is in charge of it.

Then also at that time it became apparent that Carleton was not managing the budget as tightly as the situation warranted. And to make a long story short, he became aware of all of these machinations and was asked to become the president of the Carnegie Foundation. He was not to leave until the following spring or summer, at the end of the academic year, but eventually a number of us

persuaded Carleton that – there were a lot of machinations that went on back and forth that I won't get into, but it was finally decided that the best thing would be for Carleton to take that job as soon as possible. Some behind the scenes arrangements were made, and he left the school, I think, in the fall of '72, and Marsh Tenney then became the acting dean once again. He'd been dean a couple times.

So the survey committee became a real factor. I think realistically, if the truth is known, that when push came to shove in the last analysis, Marsh and I really made the tough decisions on the plan. I don't mean to denigrate the role of the others, but Marsh was very sophisticated in terms of dealing with the trustees, and Marsh was sophisticated in fundraising. He knew the budgets. And he and I thought pretty much alike about what had to be done. What we decided to do was to develop a Draconian budget to convince the trustees that we meant business, but also to couple this with fundraising and some suggestions for realigning the budget. It was a very difficult time, and we had lots of battles within the committee and with ourselves.

During this period of time, one of the most positive influences, Bill Morton – Bill was on the committee, that's right. And Bill was a constant optimist. He would say, "Look, there's got to be a way. This is the nation's fourth oldest medical school. We've got to develop a plan." And eventually we did.

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

STRICKLER: So we had a very trying six months or so when I was in a difficult role, because for the first couple months Chapman was still dean. Marsh Tenney became the acting dean; that made it a little bit better, considerably better. But it was a difficult time because people don't like to participate in making the really tough decisions that we would have to defend to the faculty.

Also, it got a little nasty on the interpersonal side. I'm going to tell one thing here that I may decide to delete with review. Bob Vanderlinde [Robert E. Vanderlinde DMS ‘72] was on the committee and he was the number two person in the Hitchcock Clinic. Marsh and Bob Vanderlinde became convinced that Carl Chapman's poor management should be publicized and that he should be excoriated publicly. I categorically disagreed with them, and we had a very heated breakfast exchange one day on this. I said I categorically

disagreed with their recommendation for two reasons. I said, "Number one, Carleton Chapman may not have been the most clairvoyant fiscal manager, but the responsibility was not solely his." I went back and said, "Look, Dartmouth College trustees did not do due diligence, and where was the president in all of this?" And I said, "And then there was the economy and the change in federal funding. It's much more complex than that. But even more important is that we've already agreed that if this school is to be salvaged, we need to have a major fundraising campaign in the behalf of the school." And I said, "If you're going to try to raise money from responsible donors, they're going to want to know why the school got into real difficulty, and you're not going to be able to say, 'Oh, well that was the dean's fault because the astute people in the world are going to say, 'Where the hell was the Dartmouth Board of Trustees in all of that?'" And I said, "I categorically disagree."

But they persisted, and I said, "All right. Let's go to John Kemeny, and we'll have our debate in front of Kemeny." Now, you can imagine it was not an easy decision for me to make to debate Marsh Tenney in front of John Kemeny, but I decided that I was going to. I just felt strongly on this. And they said, "No, you can represent our point of view to the president." I said, "Look, I'm giving you the opportunity. We don't agree, and I'm not sure how objective I can be speaking in your behalf." And they said, "Well, we trust you to do that." So I went to Kemeny, and I told Kemeny this whole story as objectively as possible, and he said, "They're mad. They're absolutely mad." And he supported me 100 percent. (chuckles) Actually, Marsh and I, we got a long very well after that. It was no breach. But it was an example how difficult the times were during that period.

During all of this process, there was an active search on for the dean, and I was being put forth as a candidate. To this day, I think, in large measure, I was a candidate because the school situation was so bad that there was real concern about attracting somebody from the outside. Part of their strategy was that, "Well, if Strickler can participate in the analysis and knows what has to be done, then he should be the logical candidate." And in large measure, that's why I became dean. I was named dean in April after the survey committee report. In fact, I participated in the presentation to the trustees.

I remember going up to the blackboard. I presented the report and the recommendations. And Monty DuVal, who was still then the secretary of health, got up to the blackboard and said, "Gentlemen," –

there were no women on the board – "you essentially have the following decisions: Number one, close the Dartmouth Medical School. Let's discuss the pros and the cons. Then accept the report of the committee to proceed with the recommendations." I mean, it was a hardheaded meeting. I participated. They let me stay at the board meeting – 90 percent of it – until they went into executive session. But throughout my deanship, there were members of the board who felt that the school ought to be closed, that it was too much of a drain on Dartmouth College.

It was Bill Morton more than anybody else who persuaded those trustees. I'll never forget Bill listening to the discussion, listening to the debate and finally getting up and saying, "Gentlemen…" As part of our recommendation, we had recommended an immediate capital campaign for twenty million dollars. Twenty million today seems like nothing, but you remember in 1973, that was probably the equivalent of two hundred million dollars. Bill listened to all this, the pros and the cons, Dartmouth can't afford this, it's a drain on their resources. We ought to close the medical school and now's the time to do it. And Bill Morton got up there – he was then president of American Express – and he said, "Well, we've listened to this discussion, but I'm not about to participate in the closing of the nation's fourth oldest medical school. And what are we talking about here and debating? Twenty million dollars? That's only money." Then the tide began to turn and then they went into executive session. I've forgotten whether it was that evening or the next morning – it was very quickly afterward that John Kemeny got hold of me and said, "Jim, I want you to know the trustees voted to accept your committee's recommendations."

John had, all the way along, sort of kind of signaled me that I was his choice to be dean. And I think, realistically, I became dean because the school *was* in dire financial difficulties. I think, realistically, it would have been very difficult to recruit somebody from outside. Plus, I knew the finances. I had developed a plan that would eventually resolve or put us on the right track. And I then was named dean.

Then to finish off the financial story is that my deanship was essentially a deanship of saying, "No, you can't do this." By the way, that report of the survey committee, at Kemeny's insistence, we required our executive faculty, the advisory board, to vote it and recommend it. So when I came into the deanship, I could turn to the chairman and say, "You voted for this. You don't like it, I know, but you voted for it." And I even had some chairmen say to me when I

was dean, when they would submit a budget way in excess of what – I'd say, "But look, you voted –" “Well, I had to just to get it through the trustees.” And I said, "Yeah, but that's not fair to me and we're going to stick to that."

Let me just finish off the financial story and then we can come back to everything. Now I've got to carry it through. The first several years we started this so-called "rifle shot" fundraising campaign, and it really didn't work.

DAILY: Rifle shot? Oh, pinpoint.

STRICKLER: Pinpoint. And it really didn't work very well. Then one of the things we did do as an outgrowth of this survey committee report, we really built a strong development department and brought in probably the best development officer the school has ever had, Patricia King. I had the tremendous advantage – you've heard all the disadvantages of my deanship – but one of the advantages that I had is that the president and the trustees had committed themselves to helping the school. With some reluctance, but they had voted it. So I had leverage with Dartmouth College development that no dean has ever had since.

Then Bill Morton came on as the trustee representative to the board of overseers. We created the board of overseers during my deanship as an outgrowth of this whole process. In fact, we recommended that in the survey committee report because we wanted to try to give the trustees assurance that there was a better mechanism in place through a board of overseers to see that they didn't get sandbagged again. Bill Morton came on the board of trustees and Monty DuVal became the first chairman, as we moved into this new managerial mode. And Bill gave a major contribution when he accepted his role as my mentor, really, and the trustee representative. Bill and I became close personal friends after that. So he was a giant.

The other person who was a giant in this was John Kemeny. Later on, I want to give you a whole talk on John Kemeny. But John Kemeny was the best boss I ever had and the best friend this medical school ever had because he became determined this school was not going to close during his presidency.

Eventually, we developed – a capital gifts campaign was launched in 1975. It was a big campaign for the entire Dartmouth College, and we all participated in the goals and objectives – and John was very good

at this – for the whole institution, but specifically for our areas. The medical school was put in at twenty-five million dollars, which seemed like a lot of money. We raised thirty million dollars. It was a very successful campaign. We built a very strong development office. Pat King came in [Patricia A. King]. That's when we developed the *Dartmouth Medicine* magazine. We brought in a full-time editor. We developed a department of alumni affairs. We built a whole Dartmouth alumni development office, which had never existed before. And that was crucial long-term to the PR and the development of the school.

And the final thing on the chapter of the finances is that we had a second review of the finances toward the end of my deanship that Henry Harbury [Henry A. Harbury] chaired under the aegis of the Dartmouth Hitchcock Medical Center. It became clear that we needed to do some additional things, and that's when we developed the Brown program.

And one other thing. There was a second study done under the aegis of Howard Newman [Howard N. Newman '56 TU '57], the president of the center, and Bob Crichlow [Robert W. Crichlow], who wanted to rethink our financial strategies. One of the key things in that report was a recommendation that the Dartmouth Medical School expand the size of its class for the first two years of medical school. Because it was realized that we had the capacity to educate more students in the preclinical years than the clinical years. That meant more tuition, and the recommendation was that we bring in twenty more students in the first year class. That number would persist through the second year, so that would be forty more students. And then we needed to develop another clinical campus to transfer them to. We projected that the tuition for an additional 40 students at $10,000 per student would be $400,000. By the way, when we were thinking about that, people thought we were crazy. They said medical school tuitions aren't going to go up just $10,000 a year. So that became part of our fiscal planning, i.e., our tuition projections were actually quite conservative.

Then we explored the possibility of developing a second clinical campus. In retrospect, some of it a little bit crazy. Marsh Tenney had a close friend and associate from California – I don't know whether you've heard this caper.

DAILY: I saw the thing about the program with Maine in the records, but I haven't heard about –

STRICKLER: Well, before Maine, Marsh Tenney had a very close friend who was head of cardiology at the Pacific Medical Center in San Francisco that had been the teaching hospital center for Stanford before Stanford moved to Palo Alto. One thing led to another, and through Marsh Tenney, our faculty began to pursue the possibility of developing a clinical campus, would you believe, in San Francisco.

Marsh, who was one of the most analytical, objective people I've ever known, was wildly enthusiastic about this. I thought it was a fascinating out-of-the-box idea, but when push comes to shove, not very realistic. But we sent out a faculty team, and we conducted a series of negotiations. I had a few wonderful trips to California, and I even envisioned my life after dean as moving to California and being on that campus. Then it all sort of came to a halt when – I basically in my heart of hearts knew it just really wasn't very realistic. They needed to raise an endowment to develop that campus out there.

Then I talked with the chancellor at U. Cal San Francisco, which is really a great medical school. And I started doing my homework, and it turned out that San Francisco had the highest ratio of doctors to population of any city in the United States. It was the most over-doctored city in the country, and the principle reason the Pacific Medical Center wanted Dartmouth in there is because they wanted to go head-on-head with University of California San Francisco Medical Center in their residency programs, and they wanted an academic, and they wanted a prestigious name. And all things considered, it just didn't make sense and we dropped it.

Then the question came up about the Maine Medical Center, which for the same reason as the Pacific Medical Center needed to affiliate with a medical school. Tufts actually had an affiliation with them. The head of the Maine Medical Center was the former dean of the University of Vermont, Ed[ward] Andrews. We went over there and visited and negotiated with them. Then that finally fell through. That fell through for political reasons as well, because Vermont and Maine Medical Center had some agreements that really couldn't be abrogated.

Now, while this was taking place, I happened to become close friends with the dean of the medical school at Brown, Stan Aronson [Stanley

M. Aronson]. Stan Aronson and I formed a club of New England schools called the "Endangered Species Medical Schools." It consisted of Dartmouth and Brown and, at that time, BU, which was in very deep financial difficulty. Stan and I went off to a meeting – actually to a junket – in Pensacola. The navy was trying to recruit physicians, and we decided it was a great opportunity to get away in a February and get out of here. So over vodka one evening we were talking about ways in which our schools might cooperate, and I was telling Stan about Dartmouth. And Brown had the reverse situation. They had a capacity to educate more medical students in their clinical years than their preclinical years. Suddenly, Stan and I said, “My God, we could help each other. You can increase your alumni, and we can do this." And one thing came together, so we decided that this was something we wanted to pursue. It took us two years to convince our schools. He had problems with his faculty, and curiously enough, I had difficulty convincing John Kemeny.

DAILY: Why was that?

STRICKLER: Well, I'm not 100 percent sure. What we had put together was a package that would, in effect, resolve the financial problem of the medical school. We were running about a $1.2 million a year deficit. We had, by that time, agreed that we could address about a third of that deficit by the fundraising campaign, a combination of new endowment plus a ten-year expendable fund, about $400,000. We had also agreed in our Dartmouth Hitchcock Medical Center negotiations that about three or four hundred thousand dollars could be realized by new financial arrangements with the hospital and clinic. We were about four hundred thousand dollars short. And we could bring in four hundred thousand in tuition without a capital expenditure or hiring new faculty. I thought it was a very sound plan. We had gone over this. Marsh and I had gone over it, and it basically was a sound plan.

Kemeny was reluctant. He was just not enthusiastic, didn't want to bring it before the trustees. I was puzzled, and I finally went to Leonard Rieser. I reported directly to the president and not to the provost. Leonard was the provost and had become a confidante and a good friend of mine. I went to him, and I said, "Leonard, I don't understand why John Kemeny doesn't really accept this proposal." And he said, "Well, Jim, I'm not sure either. I think it's John's ego. I don't think he wants Dartmouth Medical School's salvation to be

dependent on another Ivy League school." And that's the closest we could come to it.

Finally, one day, I went in to see John. I always arranged with his handler, Ruth [LaBombard], to see him on controversial issues at a good time for him. I said, "I want to present my Brown proposal again to John, and I want it at a time when he's likely to be *the* most receptive, which means you've got to pick the right time." She said to me, "Okay. The trustees are going to be here at such and such a date, not before the trustee meeting, not the day after, but the day after that his schedule looks fairly light. The trustees meeting will be over." So I went in to John and we sat down. I said, "John, I'm here today to talk about the Brown/Dartmouth proposal." I knew John quite well by that time, and I could tell by the rapidity with which he reached for his cigarette that this was something he didn't want to discuss. But he was very gracious.

The one thing about John is that, if you had done your homework, you could disagree with John and he wouldn't get angry. John actually relished debate, in part because he had such a strong ego he figured he could win most debates, which he could, most of the time. But that was one of the great things about him as a president.

So I presented the argument. I said, "John, we've agreed that, roughly speaking, the deficit is going to be 1.2 million dollars and it's going to increase with inflation, and that we can resolve a third of this with fundraising. We can resolve a third of it with hospital clinic negotiations. And, John, I can show you why the Dartmouth Brown proposal will net us four hundred thousand dollars minimum. John, we've balanced the budget!" And I said, "John, you know me well enough now that I would not come to you with these figures if I hadn't gone over them in detail with my colleagues, and we can defend them." He said, "I know you well enough now to know that you would not do that." He pulled on his cigarette and looked at me and said, "Jim, you've persuaded me I was wrong." And that's how the Dartmouth Brown program got off the ground.

And that's one of the reasons I have such great respect and admiration for John Kemeny, because you could reason with the man. And if you'd done your homework and you presented your case, John was very receptive and could change his mind and admit to you, "Jim, I was wrong." He was a great, great man.

So when you come down to it – and your question in there, cycling back – Bill Morton was key to this because he was inspirational to the trustees; he was a tremendous supporter of the medical school. But if I had to pick the true giant in this, the tallest of the giants, I would say John Kemeny. The Dartmouth Medical School would not have survived without John. And I'll close it by saying, towards the end of my deanship when it became apparent we were – we didn't balance the budget when I was dean, but we put it on a trajectory. We had projected to the trustees that the budget would be balanced, I think, in two years. And Bob McCullom told me later it was balanced in one year.

During my going-away activities, I was with the trustees and I think John Kemeny and Dave McLaughlin [David T. McLaughlin "Dave" '54] and trustees were congratulating me and saying, "Jim, it looks as though the school's on track now and you've saved the school." I went into a little talk about how this was a team effort, and I said, "Look, yes, I played a significant role in this, but the real credit goes to Bill Morton and John Kemeny." And Morton stopped me and said, "Strickler, stop it!" He said, "Take some of the credit, damnit, because let me tell you something, if it hadn't worked, guess who would have gotten the blame?" (chuckles)

But it really was a team effort, and it was a board of trustees that, whatever their ambivalence about the medical school, bit the bullet and said, "We're going to support the school." They didn't understand at that point what that really meant long-range.

One of the interesting things during this period with the trustees is that the outstanding opponent, Don – it's interesting how I've forgotten his name. He was a lawyer from Colorado. Somehow or other he and I hit it off personally – Don McKinlay [Donald C. McKinlay '37]. Yet he was the most adamant opponent and the most vociferous opponent to continuing the medical school. Even after they'd voted, he was very skeptical about whether the school could survive. But to his credit, when I would report periodically to the board of trustees and I would prepare a report for the trustees, McKinlay would call me from his office and say, "Jim, I've read your report and I have some questions that I'm going to ask you, and I want to give you advance notice what these questions are going to be."

At the meeting one time – I'll never forget – after he'd really intellectually kind of taken me over the coals. Let me put it this way:

He questioned me harshly about this. And at the end of this, he said to me, "You know, gentlemen, you know my position on the medical school, but one of the things I want to say in front of this whole group, we should be thankful we have Jim Strickler as the dean because, although I disagree with continuing the medical school, I know I can trust Jim and what he tells me." So that I had probably better relations with the Dartmouth Board of Trustees in extremely difficult times than any of my successors could possibly have had. And it really kind of evolved out of chaos. (chuckles) That's the great irony of it.

DAILY: This is a good place to stop if you like.

[End of Tape 3, Side A – Beginning of Tape 4, Side A]

DAILY: Today is September 24, 2002. Once again I'm talking with Dr. James Strickler, former dean of Dartmouth Medical School. The last time we met, you had mentioned that we should talk about the 8x8x8 Society.

STRICKLER: The 8x8x8 Society is an interesting part of the Dartmouth Medical School history, and I will tell you specifically about the society from my recollections as a first-year medical student at Dartmouth Medical School. The society functioned only at the end of the academic year after the completion of the course on human anatomy. I first heard about it when I received a message, I think, from the dean's secretary in the mail saying, "Congratulations! You have been elected to the Society of the 8x8x8."

Now, I'd heard about the society and I knew what it was. It was the group of medical students that buried the bodies that we had been working on for almost a whole year in the anatomy lab. What happened at that time was, at the end of the year, the diener in the anatomy laboratory, whose name I still remember, Charlie Devaux, would take each cadaver – I know this sounds pretty gruesome, but this is what they did – and they dismembered it and Charlie put them in a container – it was a metal container of some sort – and welded them together. We had, I think, seven or eight bodies and each one of them in this container.

What happened is that we were asked to appear at the medical school at a specified time, and as I recall, it was early afternoon on a Saturday. It was, I think, during our exam week or just prior to the exam week. We were put into a panel truck so we couldn't see out. They had it arranged so we couldn't see out of the truck. And we got

in the truck, and I think there were eight of us. It may have been eight medical students, or perhaps six. I don't remember. At any rate, we were driven around for half an hour to forty minutes and eventually wound up in a field, which we could not identify at all. We dug a hole in the ground, 8x8x8, and that's where, really, the name came from. It basically was a common grave.

We did that in the afternoon. Then we were instructed to return to the medical school, as I recall, about eleven o'clock or ten-thirty at night. Once again we were put in the panel truck but this time with the cadavers in the containers. All of this was orchestrated by Dean Syvertsen, who did sit up in the front seat with the driver during our comings and goings. We went out to this unknown field and we put the bodies in. Then precisely at midnight, Dean Syvertsen read a passage from the Bible and we filled up the grave and shoveled it. Essentially, he was reading “ashes to ashes and dust to dust.” So that was the burial routine.

The people selected, it turned out to be Syvertsen's favorites in the class, so there was a little bit of jealousy involved from those who found out that we had been elected to 8x8x8. Then in reward for our doing this, the following night, which I think was a Sunday night, Syvertsen took the Society of 8x8x8 to the Outing Club for a lobster dinner.

So that was the 8x8x8. Now, flash forward to 1973, and I was dean of the medical school. By the way, that practice was stopped. Somewhere along the line it was discontinued. I can't tell you exactly when, but it had been stopped by the time I became dean of the medical school in 1973. Shortly after I was dean, I got a call from the vice president – I've forgotten what his title was. He essentially managed all non-academic affairs. It was a fellow by the name of Rodney Morgan [Rodney A. “Rod” Morgan ‘44 TH '45 TU '45]. And Rodney Morgan, he was in charge of B&G [buildings and grounds] and the Hanover Inn, all the non-academic stuff. Rod called me and said, "Jim, Dartmouth College is excavating some land out here." It was out by the gravel pit that the college owned. It's a gravel pit out on the Lyme Road. It may still be there. And the college wanted to expand the gravel pit, and they were expanding the gravel pit into a field. He said, "We uncovered something that looks like it might be an old graveyard. Somebody said that maybe the medical school had something to do with that." And he said, "Would you know anything

about that?" I paused and said, "Rod Morgan, you won't believe how much I know about that." (laughs) And then I told him the story.

DAILY: So you didn't reinitiate that custom when you were dean I doubt. [laughter] Once in the older records, early 1800s, I came across where the town was mad that the med students were digging up graves to get cadavers, and the dean had to apologize.

STRICKLER: Then there were some other things. It is also alleged that – I don't know whether this story's apocryphal or not, but I heard that somewhere in the 1800s at a time when matins was required in Rollins Chapel. The students had to attend, I think, at 8:00 a.m. in the morning, or whatever time, for a ten-minute service matins. For whatever reasons, the med students, as a joke, took a cadaver – it was in the wintertime – and positioned him in a chair with a hat and left him there. So when it came time to leave, the person was coming around and shook the cadaver, “It's time to leave.” And the story is that this cadaver fell over.

But medical students are – even in my day – cautioned about respecting the deceased and not to do pranks, particularly with the public; that this was really terribly disrespectful. And I agree. But medical students, like everybody else, under circumstances like this, will sometimes let their sense of humor get out of hand.

So that's the 8x8x8.

DAILY: Okay. Another thing we can talk about today that was mentioned after we turned off the tape last week was the DHMC relationship and the complexities of that. Then you also mentioned that you'd like to talk more about John Kemeny.

STRICKLER: Right.

DAILY: Maybe before those two things, could we talk about the board of overseers and bringing that –

STRICKLER: Sure. Let's close that loop. Before I became dean, there was not a board of overseers. There was a board of overseers for the other associated schools and, I believe, the Hopkins Center. So there was a precedent. But the medical school had never had a board of overseers. So as part of our survey report that I spoke about in the previous session, one of the recommendations to the trustees was to

create a board of overseers of the medical school. Marsh Tenney and I really promoted this because we wanted the trustees to continue the Dartmouth Medical School, and we put that in there as a proposed mechanism for providing more oversight to the school to help to try to reassure the trustees of Dartmouth College that the fiscal problem that had arisen would not occur with proper supervision, and with the understanding that the overseers would be, of course, advisory to the trustees of Dartmouth College.

The trustees agreed to do that, and I was involved with John Kemeny in setting up the first board of overseers. Actually, I think I wrote the charter of the board and the composition and rotations, did all the things you do when you set up a board. I think I – I *know* I did that, and I think I was the primary author, maybe even the exclusive author. I don't remember. At any rate, we set up a board of overseers.

Now, there was one interesting twist to this. Marsh and I envisioned this primarily as a board of academic people that would periodically review the academic programs of the medical school and the budget and then report to the trustees. We were envisioning this board to be primarily academic educators of distinction. But the college, and particularly the development officers, had another idea and they insisted we add people that could be helpful to raising money. Or as George Colton [George H. Colton '35], who was then the vice president of development, said, "We think we should include influential affluential people." (chuckles) So the composition changed somewhat. And I think that was a move in the right direction. One of the reasons is because the accreditation process of medical schools now is very intense and reviews in anguishing detail the budgets of the school, the academic programs, et cetera. So the medical school is really critiqued by professionals today.

So that was the board of overseers. And the first chair was Monty DuVal, who was just leaving the office of assistant secretary of health. This was before HEW. And Monty was an alumnus of the Dartmouth Medical School, and he was the first chairman of the board of overseers. The other members are all recorded. But we did include *ex officio* on the board of overseers the head of the Hitchcock Clinic and the chairman of the board of the hospital. That was very deliberate.

DAILY: Was anyone from the college board of trustees on there?

STRICKLER: Yes. There was a college trustee, and that was Bill Morton; the president of Dartmouth College, who was faithful in attending these, John Kemeny; the head of the hospital; the head of the clinic; and then a number of other members. We had, for example, Bob Ebert, who was the dean of Harvard Medical School. After that, we had Alexander Leaf, who was the very distinguished chair of medicine at Mass General; Marian Heiskell of the Sulzberger family, *New York Times*. She was married to Andy Heiskell, who was chairman of Time-Life at the time, I think. And Rhoda Teagle who was from Woodstock, Vermont. We had Collin MacCarty who was head of neurosurgery at the Mayo Clinic. We had a good and useful board. And the board has persisted to this day.

DAILY: Were there any particular issues that they really helped you grapple with, including the budget, but maybe beyond the budget as well?

STRICKLER: Well, we spent a lot of our time – not only in the board of overseers, but we spent a lot of time grappling with the issues, the governance of the center and with the Dartmouth Hitchcock Medical Center. And also a strategy for fundraising. We really didn't get into, at that time, many academic issues. It was mostly governance and funding and development of a campaign. Those were the highest priorities of the board of overseers at that time.

DAILY: Why don't we launch into the DHMC issues. One of the things I came across in the records was the joint council of DHMC in 1976 asked John Hennessey to study the center and to recommend changes. What precipitated that particular study?

STRICKLER: Okay. Well, the Dartmouth Hitchcock Medical Center, you see, did not exist until we went to a degree program. And it actually, as a center, did not exist until either just before I became dean or just after I became dean. What became apparent as the medical school's crisis unfolded and became increasingly apparent during the survey committee's studies, that the center did not have an effective governance structure – I'm using the term "center" before it existed. The medical school/hospital/clinic relationships were very complicated and, frankly, contentious. The trustees of Dartmouth College in particular felt that we needed a better governance structure, because the medical school's activities and finances were so intertwined with the Hitchcock Clinic and the hospital and that just having three separate corporate entities without a better governance structure was just not desirable.

Now, I played a significant role in this too, because I had just come from the New York Hospital Cornell Medical Center, where they had established the first center at New York Hospital Cornell. I had been working before I came to Dartmouth with the first president of the center, so I had experience with the formation and evolution of a medical center that involved several corporate entities. So the Dartmouth trustees, John Kemeny, and I became convinced that we should establish a center and that we should develop a governance structure that would help to manage the center and also avoid the kind of problems that had unfolded with the finances at the medical school.

What it really boils down to is that – two points I would make here – the medical center primarily consisted of the Mary Hitchcock Hospital, the Hitchcock Clinic, which was then an independent corporate entity, the Dartmouth Medical School/Dartmouth College, and also the Veterans Hospital in White River Junction. Now, in management terms, this is a matrix organization. What that really means is that these corporate entities, in terms of their primary mission, have different primary missions. The hospital is primarily concerned about provision of high quality inpatient care. The Hitchcock Clinic was a provider organization comprised of Hitchcock Clinic physicians primarily and nursing staff and their primary mission is to deliver high quality medical care. And the medical school's primary mission – the mission is twofold – is education and research. And the VA has a mission akin to the Mary Hitchcock Hospital, but it is different in that it's an agency of the federal government.

So each of these organizations has a different primary mission, but all of the organizations participate in the missions of the other organizations, so we're not talking either/or. The hospital has a responsibility for teaching and education, the medical school clinical faculty have responsibilities for patient care, so there are cross purposes. But if you look at the primary mission, they're different.

So really, it's a problem of management of organizations with different missions. And also, as a corollary to that, there are budgetary implications to this primary mission so that, for example – I could give you many, many examples, but let's take the teaching of medical students, which takes place in the hospital in inpatient and outpatient departments. Teaching takes additional time. Faculty has to be reimbursed for teaching, and the reimbursement for teaching comes out of the medical school budget. The medical school academic

offices were in the medical school, and we had to rent space from the hospital. I could go on and on. There are lots of budgetary exchanges, negotiations, and so forth, for this matrix organization to function.

What was clearly not working well was having each organization and each of the board of trustees acting pretty much independently. One of the things that this did was, to some extent, to pit the chief executive officers of each organization against each other, inevitably. Because each of us trying to do their own job would have to be, at times, pretty forceful. I'll give you an example. My responsibility was to save money and to balance the budget, so I had to be very hawkish about financial arrangements. At one point, I felt that the hospital was overcharging us for the space being rented to the medical school. I had a financial analysis done by people, and of course, I was immediately in negotiations with the hospital director. We had to decide lots of things, for example, the salaries of clinical faculty who spent time teaching but were predominately clinicians. Who reimburses them? For what portion? Conversely, the faculty member who's primarily research but teaches part-time, we had to develop fiscal mechanisms. So I could go on and on. There are many complexities to this.

In the best of all possible worlds, the chief executive officers will sit down and work things out. But at a certain point, each one of the chief executive officers feels that he or she can't yield, and some sort of adjudicating process or governance process has to come into play. So we proposed – and it was primarily the college – that there be developed a center structure that would provide governance oversight. What we proposed was a structure that included the trustees from each of the organizations and the chief executive officers: the dean of the medical school, the director of the hospital, the head of the clinic. And that this be set up as a board called the Dartmouth Hitchcock Medical Center Board that would serve as the top governing agency of the center.

Now, this gets very complex legally because the center, which was actually incorporated as a separate legal entity, couldn't tell the trustees of Dartmouth College what to do, or the trustees of the hospital, or the trustees of the clinic. But the way things worked is that if the Dartmouth Hitchcock Medical Center Board debated an issue and reached a resolution – which they did most of the time – then it was the responsibility of the board members to report back to

their appropriate organization and get approval. This also was enabling to the chief executive officer. For example, if I had an issue that I wanted to take to the medical center board, I was very, very careful – particularly if it was contentious – very, very careful to do my homework and to make the case before the Dartmouth trustees and persuade the Dartmouth trustees that this was a reasonable position. I think that that's a structure that is desirable.

In addition to that mechanism, we established an office of the center and hired a center president. The center president had an office and was entitled the president of the Dartmouth Hitchcock Medical Center.

In a flash forward, and I can't fill you in on all the details, but it's my understanding that that medical center essentially has been – well, the term that I hear, it's really been emasculated, and the office of the center presidency has been abolished and that it really does not function optimally as a medical center now and is more back to the old modis operandi where, de facto, the CEOs are being pitted against each other, and so on and so forth.

Whatever the structure is right now, I am told by people involved the last ten years that the center concept really has been watered down, except for PR and publicity services, so that to the outside world, it is still advertised as the Dartmouth Hitchcock Medical Center. But organizationally – I am told, this is second and third hand – that it's not a really strong center governance mechanism. But others could be more specific and elaborate on that than I am. I do believe that a strong center is important.

Now, why in 1976? Well, there was a lot of contention at that period of time, and also, we got a president of the medical center who alienated a number of people. This was Howard Newman. In all fairness, I'm not sure how much of this was Howard's doing and how much he was caught in a vice. This was a very difficult period of time. I was an active player in this and probably contributed my share to the chaos, but we had some difficult times. John Hennessey was, I think, still dean of the Tuck School, and he was a very good member of the board of the hospital, and he was really called in to reassess the center.

This gets very complex, because when the medical school went to a degree program, the realities are that Dartmouth College began to recruit outsiders, academic faculty from other institutions, to build the

academic departments. So the agenda of Dartmouth College and Dartmouth Medical School was to design and plan a preeminent medical school that is nationally recognized and internationally recognized. The number one priority is to provide excellent medical education and to do good biomedical research, which then, if well done, leads to this national recognition that I'm talking about, and if one really wants to aspire, to international recognition. So that was our priority.

But as I think I mentioned on the last tape, the priority of the Hitchcock Clinic – good people, good physicians – was not national recognition, was to provide high quality care, largely to the local region. The hospital board of trustees certainly did not aspire to have Mary Hitchcock Memorial Hospital in the top echelon nationally, or internationally. They had a totally different mindset. And this threw us into lots of conflict. I'll give you one example: the formation of the Norris Cotton Cancer Center. I did a major battle on this one.

[End of Tape 4, Side A – Beginning of Tape 4, Side B]

STRICKLER: We're talking about the Norris Cotton Cancer Center. When it came to establish a separate center, the then medical director, Bob Vanderlinde of the medical center, and the hospital were very much opposed to creating a cancer center.

DAILY: Why was that?

STRICKLER: Well, they did not feel that there was a need. They said that all of these activities can be subsumed or be the responsibility of existing departmental structures, and there is no need to create a center. And I categorically disagreed. The reason was that to compete for federal funding for cancer research and training, to get the big bucks, the federal government said you have to have a separate cancer center distinctly different and governed differently than the ordinary departmental structures in hospitals and medical schools. Moreover, to recruit a distinguished head of this center – and we wanted somebody who was distinguished academically – we had to have a center.

We had a knockdown, drag-out battle on this. And I kept saying to my confreres, "Yes, I understand your point. In the abstract, we could do all of this with the existing structure. But the hard, cold reality, guys, and it's not my doing, is if you want to compete for the federal dollars

for cancer centers, you have to have a cancer center. It's as straightforward and as simple as that. If you want the money and you want to get the kind of people in here, that's the hard, cold reality."

DAILY: What did they say to that?

STRICKLER: Well, they said more or less, "That's what the medical school aspires to, and this is the way you're going to get your research dollars." I can't remember how we finally resolved it, but I know at some point I said, "Let's take it to the board of the Dartmouth Hitchcock Medical Center and we'll each make our case." And I think, actually, we never debated the issue before the board. But that's the kind of process, and there are many, many other examples.

Another one was primary care and the relationships to the community. Because the Hitchcock Clinic said, very honestly, "We cannot accommodate your students in the primary care curriculum. We just don't have enough primary care." So we had, in the medical school, to develop a whole set of primary care relationships outside of the medical center, with community practices and, eventually, family physicians. And we had to do this because primary care education was really coming to the fore and was increasingly required for accreditation. We were driven by the academic educational needs. And the Hitchcock Clinic said, sort of off the record, "We have to have a certain amount of primary care for the local community, but we're not really into developing a primary care network." And they were very honest. They said, at that time, that 75 percent of our income comes from inpatient services.

So we had again a different priority. And that extrapolates into all kinds of things: need for space and budget and, eventually, hospital privileges for our clinical faculty. And that was a hell of a contentious issue because it was a closed hospital, and still is to this day, except for members of the clinical faculty of the center. What the department of community medicine had done was developed a teaching clinical faculty of non-Hitchcock Clinic physicians. If you looked at the rules and regs, they said that anybody who is a member of the clinical faculty is eligible for hospital privileges. And all of a sudden, we had this cadre of community physicians. And boy, that was a knockdown and drag-out battle. It eventually almost went to court.

There were lots of issues that were very contentious. And part of it had to do with the history – for example, the hospital board of trustees

at that time were good people. I don't want to disparage the individuals. But they were, essentially, local merchants. They didn't have the vision of a board of trustees of the Massachusetts General Hospital or the New York Hospital, and we wanted to bring trustees in who had a national vision, or even an international vision, and to bring in people that had been top level corporate executives. That was very threatening.

There were a lot of changes that had to be made, and these were the growing pains of the center. I'll tell you one anecdote here. I became very good friends with – did I mention Pickering to you on the last tape? Yes, I think I told you the anecdote about "where there's death, there's hope." I'll not repeat that.

At any rate, the governance issues have been paramount issues in the evolution of the academic medical school and the clinical departments, in the evolution of the M.D. program, which required academic clinical departments. And I think tremendous progress has been made with each dean and with the evolution of the center and the turnover of people. I think they've made tremendous progress. Many of these issues are handled much better than when I was dean, a lot of it because attitudes have changed. One example is that all of the Hitchcock Clinic physicians now recruited know that they're being recruited to an academic medical center, as compared to when I was dean when most of the clinical faculty had deliberately chosen not to spend their lives in an academic medical center. So there's a lot of changes that have taken place that are very desirable.

DAILY: It seems to me that both the hospital and the clinic would have had some recognition that having the Dartmouth name, or having the Dartmouth Medical School here, helped their enterprises.

STRICKLER: Look, these people are smart people, and the hospital, particularly the hospital director, and especially Jim Varnum, who I think has been a terrific hospital director, and the heads of the clinic have fully recognized that the name Dartmouth is an important marketing tool for them. It really is. They recognize and they know that. But when it comes down to budget negotiations, they kind of look at that as a freebie. That's an interesting point, because when I was at Cornell, we formed a Cornell group practice of faculty at Cornell Medical School.

DAILY: Was that ever considered here?

STRICKLER: Well, it was interesting. Yeah, briefly, but as a threat more than anything else. But we formed a Cornell group practice consisting of clinical faculty at Cornell. And the medical school charged the group practice for the name Cornell. I was involved in those negotiations. Actually, the law firm of Sullivan and Cromwell in New York, a very prestigious law firm, was retained to review this, because it really meant taking service acquired dollars and transferring it to the medical school. The lawyers from Sullivan and Cromwell said there was no precedent for this that they could find, but they said, “Do it and we will defend you if it's challenged.”

So when it came to Dartmouth, I actually discussed privately with John Kemeny, I said, "You know, John, the name Dartmouth is very important to the Mary Hitchcock Hospital and the Hitchcock Clinic and was particularly in relation to the clinic when they changed their name to the Dartmouth Hitchcock Clinic." I said, "John, that's marketing. That name is worth money, and I think we ought to consider charging." But John felt this would be too contentious and provocative, he didn't want to do it.

DAILY: This leads to another question. In another interview, somebody makes the statement that John Kemeny wasn't really willing – I'm going to kind of probably slaughter this a little bit – but wasn't willing to sit down and strong arm the clinic and the hospital. But then when Dave McLaughlin came in, he kind of knocked heads together in terms of getting – particularly in getting the clinic to pay more into the medical school. How fair a statement is that? Or maybe some perspective on it.

STRICKLER: Well, let me preface this with my bias so that the listener someday can know that I think John Kemeny was one of the finest human beings I've ever known and was certainly the best boss I ever had, and he was, on top of it all, a bloody genius. I think that John Kemeny was *very* supportive of the medical school. And I *know* John went to bat for the medical school again and again and again. And I think he exercised judgment at times and decided to compromise. But I think on balance his compromises were wise.

A lot of people sitting back on the periphery of the fray, I think, would have liked to have had John do more, but I think John was realistic. I really do. I don't think John was clairvoyant in understanding medical school issues, and there were times when I wish he had been

tougher. But I don't want anybody to think for one second that John Kemeny was a weakling in all of this. I think he did make some compromises, which at times got under my skin a little bit, but on balance, he was *extremely* supportive. We were in a survival mode, and I think John, on balance, was very wise.

Yes, McLaughlin came in and took a somewhat stronger stance on some issues, and he was the one who threatened a separate Dartmouth Medical School clinic. To some extent, I set him up for that. I was a factor in this and probably pushed Dave into being a little more hawkish than John Kemeny, but the bottom line was that McLaughlin wasn't very effective at doing that. He blustered some, but he really didn't effect a significant change in governance.

So these were difficult times. The thing that is easy to do is to sit back and blame individuals, and that really isn't fair to – and I say that of my adversaries at that period of time too. They were fulfilling their historical responsibilities. They were acting in behalf of *their* board that had a different orientation and a different number one priority. Some of these changes, it's very clear, have to take time. You just don't change institutions overnight. So I would be very careful – for those who listen to these tapes in the future, understand the organizational dynamics, and I wouldn't pay undue attention to who did this or who was the bad guy. None of us were perfect. I'm sure I did things that I, in retrospect, wouldn't have done. But on balance, I'm glad of the positions I took across the board.

Once again I will tell you that the Dartmouth trustees did not really understand and comprehend what it really took to be a first-class medical center. Most of the members of the Dartmouth board had no concept of the complexities of relationships between the medical school and the teaching hospital and the group practice. So this compromised, to some extent, the dean.

DAILY: I want to pick up on a couple things you said, that you wished John Kemeny had been tough on a couple different points. Do you mind going into those?

STRICKLER: Well, one of them is trite: parking. (laughs) But it's an example. It's not a very big issue. The medical school, college owned most of the space we now have as parking space there. And the hospital director started beating on me about making this center parking space. Because the medical school had more space than we needed, but it

was all on Dartmouth College property. I was reluctant because the hospital director was very aggressive, and I resisted this, probably longer than I should have.

His proposal was to pool the parking space so that it would become controlled by the Dartmouth Hitchcock Medical Center and not Dartmouth College. Now, what bothered me about this was that Dartmouth College insisted that college employees would continue to pay the Dartmouth College parking fee; the hospital and clinic did not charge parking fees. So we had people in the same office, one paying a parking fee and the other not paying a parking fee, and I didn't think that was right. The hospital and clinic wouldn't yield, and I couldn't budge Kemeny. I said, "You know, John, if we're going to have a center parking, let's treat everybody in the center the same. Either get the clinic or the hospital to start charging their employees for parking or, one way or another, don't charge your medical school employees. Let's be fair across the board." I could never pull that off, and that one annoyed me. That's a relatively minor thing.

I think that on support of academic programs, John was very good. He was very good in helping to pressure the Hitchcock Clinic to develop more favorable financial arrangements to the medical school. He strongly supported that with the hospital. One of the key concerns throughout the medical school's history has been the appointment of senior people.

Well, I'll tell you one other area where I think the college did not stand as tall as we should have and John wasn't aggressive. At that time, when the medical school dean was appointed, the clinic and the hospital were represented on the search committee. At that time – and I don't know what it is today – at that time, the medical school did not have comparable input to the selection of the hospital director and the Hitchcock Clinic. Of course, the Hitchcock Clinic always used the argument, well, that's an elected position of the Hitchcock Clinic. But in the hospital, for example, I remember that John Hennessey chaired the search for Jim Varnum, who, by the way, I think has been a superb hospital director, and John Hennessey did give me the chance to interview the lead candidates. So I had that input. But I did not sit on the search committee. In other words, what I'm saying is, the search mechanism – the college reached out to the other components much more than they did in turn for their own CEOs. And I thought that was not equitable. And Kemeny, I would have liked him to have taken a tougher stand on that.

There was another factor. The deans of Dartmouth are reviewed, across the board. Every four years there's an intensive review, and I was reviewed at the end of four years and I passed my review. And I'm pleased to say, at least from the feedback of John, passed it with flying colors. But there was no comparable mechanism for reviewing the hospital director. I never participated – yet the hospital director participated in my review, and the head of the clinic participated, but there was no comparable role for the dean in the review of the others. So there were a lot of inequities at that period of time. But John didn't feel that it was worth making a tough stand on those issues because he was focused on the finances of the medical school. We were in a survival mode, and he felt you had to pick your issues.

DAILY: While you were dean, the heads of the clinical departments, how were they chosen vis-à-vis the medical school, and particularly the clinic? I don't know if the hospital was involved or not.

STRICKLER: One of the biggest mistakes I ever made as dean was to chair the search for a department of medicine myself. I did so with the approval of the head of the Hitchcock Clinic, Jerry Foley at that time. Unfortunately, as chair of the search committee, the person we chose was not a good choice and didn't last very long. I had played a lead role in this, and once it was clear this person should not be continued on, I did step to the plate and say, "Okay, I took the lead in recruiting this person who has not worked out, I will now take the lead in seeing that he goes." And that was very painful.

What we did eventually was to develop a system where every recruit, including the chairman, is agreed to – I'm talking before we get to the actual individuals. But the position is all agreed to by the clinic, the hospital, and the medical school. And then we agreed to split the salaries of the clinical chairs three ways, and we agreed to appoint the search committee as a center committee. At my time, the chair of those clinical search committees was the president of the center, Howard Newman, and that grated on the medical school faculty because it was not the usual role of the dean in an academic medical center. I wasn't particularly happy about that, but given the circumstances, there wasn't an awful lot I could do about it.

Now, the key factor here is the Hitchcock Clinic, because that's one of the things that's different here, except for the Mayo model. But in most private medical schools, what you really have are two separate

entities. You've got your teaching hospital and you've got the medical school. The clinical faculty do not stand apart as a separate corporate entity. What was different here was that Hitchcock Clinic was a separate corporate entity and politically very powerful, and also economically very strong. So that at a time when the medical school was in the red, to try negotiate, bargain hard with the clinic, was difficult. We didn't have the dollars to put into programs – we didn't have optimal dollars. And this compromised the school.

You see, the Hitchcock Clinic has always espoused the Mayo model, where the Mayo Clinic essentially runs the medical school. And that's a model that most of us do not like. We do not think it's an optimal model; we think it compromises the development of the medical school. Furthermore, as Collin MacCarty, who was head of the medical school board of overseers and chairman of the section of neurosurgery at Mayo Clinic, said to me, "It is fatuous to compare the Mayo Clinic with the Hitchcock Clinic" at that time, and he took me out there and showed me that the Mayo Clinic was a much more academic organization. He showed me in his section, for example, what the requirements were for continuation and promotion, insistence on publications, and so forth. So I really always felt it was presumptuous of the Hitchcock Clinic to aspire to the Mayo model; and I'm sure my clinical colleagues, if they heard me say that, would say, “Well, it's presumptuous of Dartmouth Medical School to aspire to be Harvard or Cornell.” (chuckles) "You stand where you sit," you know. It’s Myles' rule.

DAILY: In our last interview, you said you could probably do a whole interview on John Kemeny, or something to that effect. Are there other things you want to talk about about John Kemeny?

STRICKLER: Yes. John Kemeny was a fascinating person. First of all, everybody who knew John would tell you John was a genius. There's no question about it. And John had strong views; John was very decisive; John had a colossal ego, which he really deserved; he had a good sense of humor; and he was the best boss I've ever had and one of the most wonderful human beings that I've ever known. I say the later in part because there were a lot of personnel situations that get a little dicey and sticky, and John was just masterful in these situations. He was a kind human being. His values were, I think, outstanding. I guess that means I agree with John's values. He was a great supporter and developer of coeducation. He was very forceful in promoting diversity at Dartmouth College: the Native American

program, bringing in minority students, developing increasing opportunities for women, not just undergraduates, and so forth. So basically, this is a man whose values I admired very much.

But there are a few stories about John that kind of illustrate. One of my first encounters with John, shortly after I became dean and he was president, I ran into him on the street somewhere. I knew he had just come back from a trip, fundraising, had spoken somewhere. I said, "John, how was your trip and how was your talk?" And he said, "I gave an outstanding talk. It was magnificent." I'm paraphrasing, but essentially, he was glowing. I said to myself, “Oh, my God. Is this what I'm going to have to work with for the next four years?”

A few months later, I ran into John. He'd just come back from another trip, and I said, "John, how was your trip, how was your talk?" And he said, "I was terrible. I gave the worst talk I think I've ever given. It was just awful." That was John. He was objective about himself. When he did well, he'd tell you he did well. When he didn't do well, he'd admit it. And I began to realize this is quite an extraordinary man.

He was wonderful at building a team. John was an introvert. He really was. He was not a gregarious, social person. But John built one of the most loyal teams that I have ever been involved with. I mean, if you talk to people on John's staff at that time, the senior vice presidents, with maybe just one exception, loved John Kemeny. We really did. We admired and we respected John. And one of the reasons we respected John is because John brought us into the fold. John, when he had meetings of his presidential advisory board, he would encourage discussion and debate on issues. He would encourage people to speak up, and particularly, to disagree with him. In his heart of hearts John knew he was probably smarter than all the rest of us and that he could win most of the debates, which he did. But you really felt that you could speak your views. But you were always careful that you chose your words.

[End of Tape 4, Side B – Beginning of Tape 5, Side A]

STRICKLER: You certainly began to enjoy the dialogue that took place in these gatherings. A couple of examples. I remember being at one of the presidential advisory meetings, and the subject of ROTC came up. Now, this is largely a matter for arts and sciences in the undergraduate college, so I and the other deans of associated

schools, we're sitting there, and John asked for a discussion. ROTC had been thrown off the campus by John Dickey, not John Kemeny, which people often think. There was some sentiment for restoring ROTC, but this was still very contentious and most of my arts and sciences colleagues were very much opposed to it. I sat back and was listening, and so was Dick West of Tuck School, and Carl Long, who was dean of the engineering school. Finally, Kemeny turned to me and said, "Jim, I'd like to hear your views." I said, "Well, you know, John, this is predominately the arts and sciences faculty's concern." He said, "Yes, I know, but you're an alumnus of Dartmouth College and you're the dean of the medical school and you've been in the service."

I gave him my views. I said, "I think there is a place for ROTC at Dartmouth and I'm sorry that it was discontinued." I said, "I really felt that this was an opportunity for people to come to Dartmouth College who couldn't afford it otherwise." And I also believed that it was important to have a cadre of officers in the military who had been liberally educated. But I also recognized that, politically, that probably wasn't the time to do it. It turns out, actually, this was Kemeny's view also. So he was able to bring people and engage them in dialogue and discussion and debate, and we really came to respect this.

John also had a sense of humor, and I can illustrate this by a session that he and Leonard Rieser and I had in John's office. I don't remember the prelude to this, but finally, at some point, Leonard Rieser, who was the provost, said to him – John said in response to something Leonard had said, "Well, Leonard, you know, there are no dumb Hungarians." And Leonard looked at him and said, "Yes, John, that may be so, but I've also noticed there are no humble Hungarians." Kemeny laughed. He could do that.

The other thing I remember, John was very proud of being a Jew, but he was not an observant Jew. It's surprising, even growing up in New York City, how shallow he was in many aspects of the Jewish culture. I knew more about a lot of the Jewish culture in New York, in part from living there at sixteen and being in medicine, and so forth. I'll never forget, one of the fall retreats he and Leonard were sitting around – Leonard was also a Jew but not observant. The presidential retreat was held at Minary every fall, so they said, “Let's hold it on this date,” and they were setting it up. I finally pulled out my calendar and said, "You know, you two guys, you've scheduled this on the high holidays?

You've got to have the goy point this out to you?" They laughed. And Kemeny laughed.

One more story about Kemeny and then I'll let you ask other questions. But this has to do with the Brown Dartmouth program. Did we get into that?

DAILY: We talked a little bit about it.

STRICKLER: Did I tell you that Kemeny finally said to me – did I say that? I've forgotten whether we –

DAILY: Why don't we go into that a little bit?

STRICKLER: Okay. The Brown/Dartmouth program was really put together conceptually by Stan Aronson, the dean of the Brown program in medicine, and myself. I'm almost certain I talked to you about this, so I'll flash forward and say it took us about two years to persuade our faculties that this we should do. Dartmouth did it primarily to help the financial problem of the school. At that time, we were projecting about a 1.2 million dollar budget per annum. I know we discussed this before.

DAILY: Yeah, because we talked about the quarters, or the thirds.

STRICKLER: To make a long story short, Kemeny hadn't been interested in the Brown/Dartmouth program, and when I finally re-presented the case to him and showed him how this would, in effect, balance the budget, he looked at me and said, "Jim, you have persuaded me that I was wrong." I mean, that's the sort of man he was. That's the sort of man John Kemeny was.

The day before he left office, I got an appointment to see him. I had it all set up with his secretary. I said, "I want that appointment and I'll tell you why I want it. Get me on, because John doesn't want the dean to be pressing him forty-eight hours before he leaves office." I went in and sat down and said, "John, I have a very short agenda today." I could sort of see him wincing. I said, "John, I just want to tell you that, as an alumnus of Dartmouth College and as a faculty member and as your dean of the medical school, I want to tell you that I think you have been an absolutely great president of Dartmouth College. In fact, you may go down as the greatest president." And I

said, "John, that's the end of the meeting. I just wanted to say that to you." So, I'm a Kemeny devotee.

You can go on and on about John, but I loved when the first women graduated from Dartmouth. Kemeny had guts too, because he got up there at the presidential closing when he addresses the freshman class, just after they've graduated. Up until this point, it had always been, "Men of Dartmouth." John Kemeny got up there and said, "Women and men of Dartmouth." And the students, 90 percent of them jumped and cheered. I'm sure some of the old green alumni put their wallets back in their pocket. (chuckles) But he was an extraordinary guy.

DAILY: Is there anything else you want to speak on in terms of medical school or John Kemeny or the center?

STRICKLER: The only thing additional I would say is that way back when the trustees made the agonizing decision not to close the school and continue, I was asked by the chairman of the board – or the recent past chairman, who was still active – whether or not Dartmouth Medical School could become a truly great medical school. I thought long and hard about that. He said, "Because, Jim, when you come to the trustees to make the report to continue the school, the trustees want to be assured that, if not tomorrow or next week, that they can develop an absolutely high quality medical school. Dartmouth should not have a second-rate medical school."

I thought long and hard about that, because having been trained in an urban medical school with resources much greater than we would likely muster in the future, I finally concluded that if this medical school and this medical center evolved over the next several decades along certain lines and with strong support of the Dartmouth Board of Trustees, that eventually Dartmouth could have an absolutely first-rate medical school.

We will never, probably, compete across the board with the Harvards, the Cornells, but we can be a very high quality school, and we can be preeminent in certain areas and a school that Dartmouth would be very proud of. I can honestly say that every dean that I've known since my days in office has contributed significantly towards the improvement and academic stature of this medical school and this medical center.

I don't think we've reached the peak yet for Dartmouth Medical School, but we're sure moving in the right direction, and I think that we're a vastly better medical school than we were when I was dean. And I think we will continue to gain strength. I am very pleased to say that the Dartmouth trustees today are *much* more supportive of the medical school – and I, in fact, think now that it would be impossible to regenerate the kind of negative thinking that took place years ago.

So I think we're moving in the right direction, and there are a lot of good people that have contributed to that.

DAILY: I think I'd like to close at that juncture, if that's agreeable with you. Thank you.

End of Interview