**The Hitchcock Clinic was one of the nation's early multispecialty groups when it was founded in 1927. Five years later, in 1932, the Clinic counted these nine physicians—including four of the five founders (circled)—as its members. Pictured are, from the left, front row, Harry French, John Bowler, Percy Bartlett, Elmer Carleton, and "Jay" Gile; and back row, Leslie Sycamore, John Coyle, John Boardman, and Colin Stewart.**

# A Long-Running Hit

**The Dartmouth-Hitchcock Clinic—one of the oldest and, today, one of the largest multispecialty group practices in the country—is celebrating its 75th anniversary in 2002. The organization's long run is cause for applause.**

By Constance E. Putnam

## Prologue

On a drive from the northern tip of New Hampshire to the southern reaches of Vermont, one is likely these days to espy more than a few green-and-white signs proclaiming that a given facility houses part of the "Dartmouth-Hitchcock Clinic." This may surprise those who recall a time when the Clinic's locus was limited to Hanover, N.H., and it was known as the "Hitchcock Clinic." Even those familiar with recent changes—such as the opening of other sites starting in the mid-1980s, the 1991 move of its main site to the new Lebanon campus, and the 1999 addition of "Dartmouth" to the Clinic's name—may be startled by the organization's scope as it celebrates its 75th anniversary.

So one can't help wondering whether the five intrepid doctors who had the foresight to create this new medical entity would also be amazed at what they spawned. Nothing in the 1926 memo in which Dr. John Bowler proposed a group medical practice suggests that he dreamed his conception—whose actual existence dates from the group's first meeting in June of 1927—would live to be 75 and counting. Nevertheless, we may do a disservice to Bowler and his colleagues—Drs. Percy Bartlett, Harold DesBrisay, Harry French, and John Gile—if we assume they could not see beyond the original shape and size of the organization they founded.

Perhaps *we* are the ones who find it difficult, given what has transpired in organized medicine in the subsequent three-quarters of a century, to grasp the full drama of successfully establishing a group medical practice in rural New Hampshire in the mid-1920s. Back then, with but a few exceptions—including the Mayo Clinic, on which the Hitchcock Clinic was modeled—medical practice was a solo enterprise. The idea that doctors might band together to offer patients a range of medical and surgical services in one setting was quite novel.

Leaving aside whether the founders would be amazed at how their creation has grown, we can safely assume that they would be pleased. Not that the path has always been clear of awkward twists and turns, of course. But today the Dartmouth-Hitchcock Clinic is a nationally respected organization and a contributing member of the many communities it serves. It takes pride in its historical roots and has a strong "culture" (that word is used repeatedly and with fervor by all those who have held leadership positions in recent years) of professional collegiality.

Longtime Clinic CEO John Collins suggests that the stages in the organization's evolution can

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*Medical historian Constance Putnam's work has appeared in* Dartmouth Medicine *many times. She also contributed to this issue another feature in which John Bowler figures (see page 52). Putnam holds a Ph.D. from Tufts University and is the coauthor (with Dr. Oliver Hayward, DMS '32) of* Improve, Perfect, and Perpetuate: Dr. Nathan Smith and Early American Medical Education, *a biography of Dartmouth Medical School's founder. In this article, some punctuation and capitalization in the historical quotations have been modernized for ease of comprehension.*

**It was 1947, and the Clinic was celebrating its 20th anniversary, when this portrait of its membership was taken. John Bowler (circled), one of the group's five founders, is generally regarded as having been the driving force behind the Clinic's creation. He served as its president (and at the same time as dean of the Medical School) for many years.**

Sometime in the spring of 1926, Hanover surgeon John Bowler took a sheet of leftover green stationery from his 10th Dartmouth College reunion and ran it into his typewriter. He banged out a memo that would ultimately change the face of medical practice in Hanover.

be viewed as the acts of a play. That then makes the actors in this drama an ensemble rather than a collection of stars, since "teamwork" has been a watchword for the Clinic.

## Act I: A radical idea

Sometime in the spring of 1926, Hanover surgeon John Pollard Bowler took a sheet of leftover green stationery from his 10th reunion with the Dartmouth College Class of 1915 and ran it into his typewriter. He banged out a draft of a memo that would ultimately change the face of medical practice in Hanover.

"To the Trustees of the Mary Hitchcock Memorial Hospital," he began. "Gentlemen: For the reasons as amplified below, it is the request of the members of the staff of the Mary Hitchcock Memorial Hospital that the Board of Trustees consider the advisability of sanctioning the grouping of the staff as a general medical and surgical clinic."

The three "reasons" he spelled out were professional service, individual efficiency, and improving the educational function of the Hospital. Bowler expanded briefly on what he meant by each and then appended three more short paragraphs of clarification. He closed with an attempt to forestall criticism from those who might be opposed to radical innovation. "By such a communication, it is not to be assumed that the proposed matter is altogether new," he wrote. There had already been, he insisted, considerable "interworking of the staff."

Regardless of how much the Hospital staff had been "interworking," formal cooperation among a group of doctors was a new idea. But Bowler had experienced such an approach during his years of surgical training at the Mayo Clinic, in Rochester, Minn., and Gile and DesBrisay had also done their training there.

By 1927, the deed was done. The Hospital trustees granted Bowler's nascent group what amounted to an exclusive franchise to practice within its walls, and the Hitchcock Clinic was born. Strictly speaking, there were five proud (and perhaps nervous) fathers of this particular newborn. Yet Bowler was clearly *primus inter pares*, or "first among equals," the one who truly possessed the ambition and desire to bring the concept to fruition. "He was pretty much running the show," is the latter-day assessment of Dr. Radford Tanzer, who in 1939 became the 16th member of the Clinic. And Dr. Frederic Lord, a longtime anatomy professor at the Medical School, wrote to Bowler in 1947 that he was "still agape at what has happened . . . at the vision of those who started it, of whom you are not the least."

Commonly credited with being *the* founder of the Clinic, Bowler was awarded an honorary doctor of science degree by Dartmouth College on the 25th anniversary of the group's founding. The citation read, in part: "In 1927 you and four far-sighted colleagues pioneered here in Hanover a venture in private group practice which has provided the entire North Country, including Dartmouth College, with the unique blessing of superb medicine practiced by men who meet their patients as they're meant to be met in these parts, as neighbors."

But Bowler could not, of course, have established the Clinic without the cooperation of his colleagues. Gile and French in particular played important roles throughout their careers, perhaps especially in the living-room discussions that constituted early Clinic meetings.

Furthermore, Bowler was not even the first head of the Clinic. In the early years, the partners rotated officer positions on an annual basis, and Bartlett was actually the first person to hold the chair (varying titles for the position were used over the years). And a 1933 *Dartmouth Alumni Magazine* article about the Clinic's fifth anniversary "mentioned no names" because "those who have been instrumental in forming this clinic and developing it would want to consider it as the work of a group rather than the contribution of individuals."

By the time of Bowler's retirement in 1960, however, he had been the Clinic's head (the term "president" was used beginning in 1942) for 18 years.

During the same 18 years, he also chaired the staff board of governors at Mary Hitchcock Memorial Hospital. And from 1927 until 1945, Bowler had served as dean of the Medical School as well.

The physicians who joined Bowler in this pioneering effort were already Dartmouth faculty colleagues of his: John Gile and Percy Bartlett were fellow surgeons; Harold DesBrisay was an internist; and Harry French practiced general medicine.

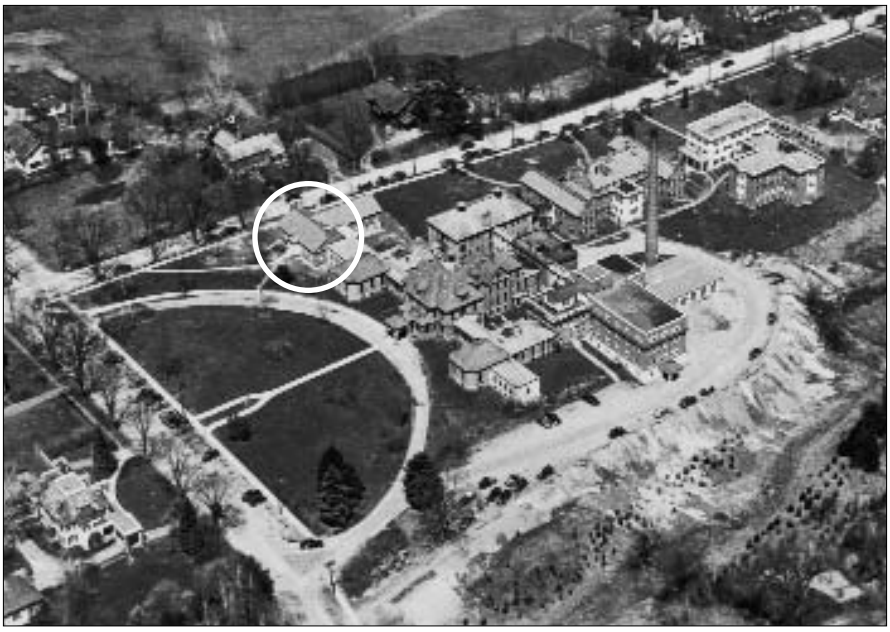
Perhaps not incidentally, Gile was also Bowler's brother-in-law; both were Hanover born and raised, the sons of Hanover doctors. Bartlett was the oldest of the five founders, in age as well as in years of service at DMS, having joined the faculty in 1904 (just four years after earning his M.D. at Dartmouth). He would retire in 1939.

French had joined the faculty as an instructor in 1916, even before finishing his M.D. at Rush (he had done two years at DMS and also earned an M.S. in physiology from Dartmouth in 1918). During World War I, he taught all the anatomy courses at DMS. He did not retire until 1958.

John Fowler "Jay" Gile began teaching at DMS in 1922. He was following in the footsteps of his father—Dr. John Martin Gile, who stepped down as dean of the Medical School in 1925—as both a surgeon and a teacher. Jay Gile carved out a distinguished career of his own, retiring in 1954. (When he died a year later, he was referred to as a "great surgeon" and a "saint in [the] North Country.")

DesBrisay, a Canadian whom Bowler had met at the Mayo Clinic, had joined the DMS faculty in 1925 at Bowler's instigation. He was, according to Bowler, "a terrific internist, highly intelligent . . . one of the most unselfish men I ever knew." DesBrisay was elected chairman of the Clinic in January of 1930 but left Hitchcock three months later. He thus did not play a long-term role in the organization, though he stayed in touch with Bowler for years and even returned to Hanover for Bowler's retirement party.

Other early members of the Clinic were obstetrician John Boardman, ophthalmologist John Coyle, and radiologist (or "roentgenologist," as the specialty was then known) Leslie Sycamore. A letter in April 1929 from Bowler to W.R. Gray, president of the Hospital's board of trustees, noted that the next recruit needed to be in pediatrics; Colin Stewart III filled that position, bringing the Clinic membership to nine. Some were "staff" (in effect, on probation) while others were "partners." For example, the first new member after the original five, Boardman, was on staff for five years before he was made a partner. Later, the minutes from a meeting on January 21, 1936, show a vote taken to establish three classes of Clinic members: junior partnership (the typical period for which was three years), associate membership, and full membership.

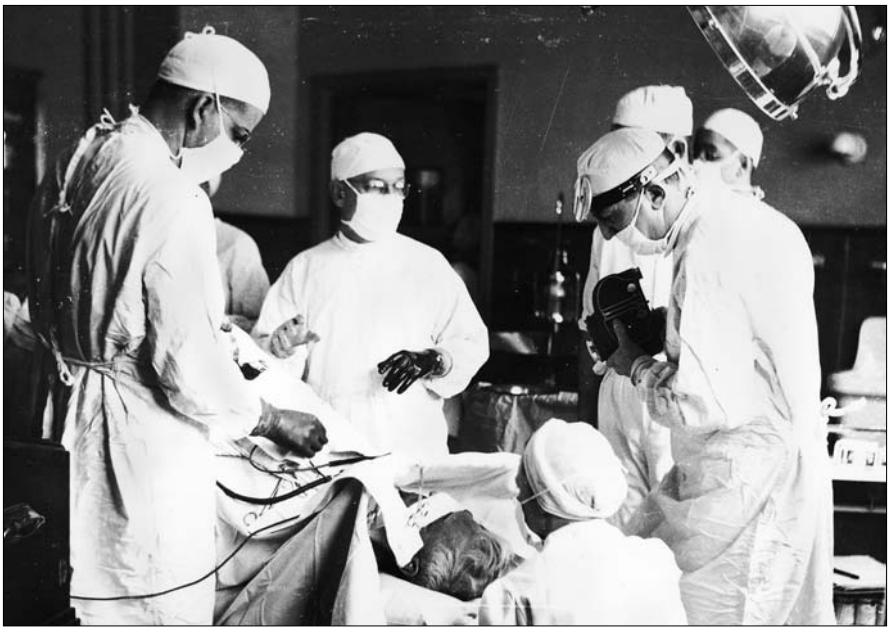


**The Clinic rented space from Mary Hitchcock Memorial Hospital rather than owning its own facilities. This photograph dates from 1943. The circled building was home to the Clinic for many years; the Hospital buildings are to its right. Although many of these structures no longer exist, the Clinic still stands and now houses the DMS dean's office.**

More than one person has argued that the founding of the Hitchcock Clinic was critical to the future of medicine in Hanover and, indeed, the entire region. In the early years, it reversed a drain of physicians from the area that had followed a change in DMS's status. An increasing emphasis nationally on bedside teaching led to a decision by the accrediting body for medical schools that Mary Hitchcock's patient population was not sufficiently large or diverse for clinical instruction, so in 1914 Dartmouth suspended its M.D. program and began offering only a two-year, basic-science course. But without the prestige of a degree-granting program, it was hard to recruit and retain clinicians—until the Clinic came along. In more recent decades, the Clinic "proved to be . . . an effective vehicle for providing a balanced cadre of able physicians" to the area, noted Robert Graham in an article for the Fall 1991 issue of this magazine.

That tensions would eventually arise between the Clinic and the Hospital (there have been periods of outright distrust between the two institutions), between the Clinic and the Medical School (in the 1960s, lawyers were even brought in by the School's administration to challenge the Clinic), or between the Clinic and local practitioners (who resented being excluded from membership and thus the ability to practice within Hitchcock Hospital) was perhaps neither altogether avoidable nor en-

But Bowler could not, of course, have established the Clinic without the cooperation of his colleagues. He was not even the first head of the Clinic. In the early years, the partners rotated officer positions on an annual basis, and Bartlett was actually the first person to hold the chair.



**Surgeon and urologist John Bowler, although he was often considered *the* founder of the Clinic, did not become the group's official president until 1943. He is pictured here (center) in 1945, in one of Mary Hitchcock Hospital's operating rooms. Also pictured are internist Scott Pedley (left front) and otolaryngologist John Murtaugh (right front).**

Without the Clinic, the trickling away of doctors from Hanover would almost certainly not have stopped when it did; that finger in the dike resulted soon enough in the attraction to the staff of new and talented physicians.

tirely Bowler's fault—although his dominance makes it difficult to absolve him altogether. His was a name to reckon with for many years, even if his colleagues and acquaintances sometimes found him to be "autocratic" and "controlling"—words that tend to come up in interviews with those who remember him.

From the Medical School's point of view, Bowler's most important service may have been that the Clinic laid the foundation for the reestablishment of an M.D.-granting program. Without the Hitchcock Clinic, the trickling away of doctors would almost certainly not have stopped when it did; that finger in the dike resulted soon enough in the attraction to the staff of many new and talented physicians.

In an address in celebration of DMS's sesquicentennial in the late 1940s, anatomist Frederic Lord observed: "Among the changes that have affected the School, none has [done so] more profoundly and advantageously than has the coming of the Hitchcock Clinic. . . . Its existence has meant an extended instruction to its students, an added stimulus to its faculty, as well as a general increase in the quality of medical care given everyone in this community."

The power of this new formula for practicing medicine was becoming clear. But some sense of just how new the whole idea was can be seen in remarks made by Jay Gile on behalf of the Clinic to members of the Hospital Corporation in 1931, four years after the Clinic's founding. He defined a "group clinic" (which would have been unnecessary had the concept been familiar) as "an organization of physicians engaged in cooperative and contiguous medical practice, using facilities, personnel, office space, laboratories, and medical equipment in common; covering, as well as it may in its own instance and as completely as possible, the entire scope of medical practice; providing a free discussion, consultation, and combined service to the patient, [regardless of] into whose hands the patient first comes and to the extent that is required by the nature of the case."

Gile distinguished this type of "cooperative organization" from "the private clinic consisting of an organization of assistants under an individual who has developed it as the result of his own private practice." He took pains to explain that this organization in no way meant a "loss of intimacy of contact with the family doctor," a common criticism of group practices. And anticipating the possibility that "the places of . . . older rural practitioners [would not be] filled by younger men," he proposed hiring a junior physician to hold itinerant office hours in any area towns lacking medical care.

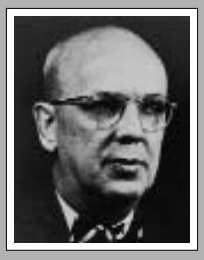
He was eager to demonstrate "that organized medicine does meet this type of practice" and that the Hitchcock Clinic in particular was not engaged in "competition with individual practitioners." That he would be proved partially wrong—"younger men" (and, later, women) *did* establish practices in neighboring towns as older physicians retired, and they have continued to do so—no one could have guessed in 1931. But it does seem clear that the members of the Clinic were sensitive to the possibility of opposition in the area to their way of practicing medicine.

Strikingly, although Gile drew attention to the uniqueness of the venture (saying that it "may be of interest to note in conclusion that the type of staff organization which we have described is the only one in New England and is probably peculiar in itself in that it is developed for the handling of so-called rural medicine"), he said nothing at all about the relationship between the Clinic and the Medical School. (Later, the question of which DMS faculty would be welcomed as members of the Clinic would become as touchy a matter as the failure of the Clinic to permit "rural practitioners" to join its ranks. As an exclusive organization from the outset, it was responsible for the Hitchcock Hospital becoming and remaining a closed-staff hospital; only members of the Clinic may practice there. In addition, all Lebanon-based Clinic members are members of the DMS faculty.)

Though Gile purported to talk only about "or-

## Clinic Presidential Succession

(Rotating Annual Appointment from 1927 to 1943 )



### 1943 to 1960

John P. Bowler, M.D.
**Specialty:** General Surgery and Urology
**Medical School:** Dartmouth and Harvard
**Training:** Mary Hitchcock Memorial Hospital; Massachusetts State Infirmary; Mayo Foundation

### 1960 to 1964

Sven M. Gundersen, M.D.
**Specialty:** Internal Medicine
**Medical School:** Harvard
**Training:** Massachusetts General Hospital; New Haven Hospital

### 1964 to 1974

Jarrett H. Folley, M.D.
**Specialty:** Internal Medicine
**Medical School:** Harvard
**Training:** Mary Hitchcock Memorial Hospital; New Haven Hospital; University of Pennsylvania

### 1974 to 1984

Richard H. Cardozo, M.D.
**Specialty:** Cardiothoracic Surgery
**Medical School:** Cornell
**Training:** Peter Bent Brigham Hospital, Boston; Saint Mary's Hospital, London; Southwestern Medical School; University of Minnesota

### 1984 to 1990

Harry H. Bird, M.D.
**Specialty:** Anesthesiology
**Medical School:** Tufts
**Training:** U.S. Naval Hospital, Portsmouth, Va.; U.S. Naval Hospital, Chelsea, Mass.; Children's Hospital, Boston

### 1990 to 2000

Stephen K. Plume, M.D.
**Specialty:** Cardiothoracic Surgery
**Medical School:** University of Rochester
**Training:** University of Rochester-Strong Memorial Hospital; Hospital for Sick Children, Toronto

### 2000 to Present

Thomas A. Colacchio, M.D.
**Specialty:** General Surgery and Surgical Oncology
**Medical School:** Tufts
**Training:** Columbia-Presbyterian Medical Center

In 1931, Gile pointed out the uniqueness of the venture, saying it "may be of interest to note in conclusion that the type of staff organization which we have described is the only one in New England and is probably peculiar in itself in that it is developed for the handling of so-called rural medicine."

**These buildings on Maynard Street in Hanover, north of the Dartmouth College campus, were home to the Hitchcock Clinic and Mary Hitchcock Hospital until DHMC's move to a brand new facility in Lebanon in 1991. This picture dates from the early 1970s, about the time the Medical Center was established as an umbrella organization.**

Even more notable was another salient feature of the Clinic's founding principles: Partners' salaries were equal. Surgeons didn't make more than pediatricians, for example. This was a radical notion indeed.

ganization," he perforce dealt with economic issues. For example, he pointed out that "the duty of the organization is to supply its maximum service in the case of any patient, and the cost to the patient is not affected by the number of men involved in the rendering of that service."

Even more notable was another salient feature of the Clinic's founding principles: Partners were salaried, and salaries were equal. Surgeons didn't make more than pediatricians, for example. This was a radical notion indeed. Not only was a specialty-based differential the standard, but nearly any successful solo practitioner in those days could earn more than the Clinic paid. Yet a firm belief that the whole was larger than the sum of its parts, and that any hard-working doctor's time and skills were as important as those of any other doctor, prevailed. No doubt in the early years it helped to even things out that the Clinic members all did a fair amount of general practice. None was solely a specialist; they could, and did, cover for each other.

In 1943, thought was given to altering this salary policy for three new hires. The argument against the change was recorded this way in the minutes of a partners' meeting: "One of the particular appeals of the Hitchcock Clinic organization is the equality of all the participating members."

Remarkably, the principle of equal salaries regardless of specialty lasted until 1979. Even today, there are stringent limits on how far apart Clinic salaries are allowed to be. There is not a surgeon at the Dartmouth-Hitchcock Clinic today who could not earn a great deal more elsewhere. This commitment to equitability is a huge part of what creates the organization's celebrated "culture."

The strength and success of the initial "cooperative organization" were by no means foregone conclusions. Bowler and his colleagues, knowing that the Hospital desperately needed an infusion of monies (Hiram Hitchcock had funded a beautiful hospital building in his wife's memory, but he had left no endowment) turned over the radiology and laboratory services to MHMH. In other words, they *gave away* the chief income-generating services, a wonderful gift that was crucial to the Hospital's economic survival. In exchange, they bargained for acceptance of all Clinic members to the Hospital staff. The Clinic also owned no real estate, instead renting space from the Hospital. Of course, these arrangements were not without benefit to the members of the Clinic. By putting the money-making centers under the Hospital's aegis, the Clinic minimized its profit—which had tax advantages.

The symbiotic relationships inherent in today's Dartmouth-Hitchcock Medical Center date from those early days and are critical. CEO John Collins says the institutions that make up DHMC are "interdependent" organizations. They take turns "carrying the heavy water" is the way past president Harry Bird, M.D., puts it. The result has been an atmosphere of remarkable collegiality—a "culture" that both attracts people to Dartmouth-Hitchcock and holds them there. Where once—actually, more than once—there was serious question whether the Medical School could survive, and where Bowler and his colleagues were concerned whether the Hospital could survive, there is now a true academic medical center.

As Lisabeth Maloney, M.D., one of two executive medical directors of DHMC, says, "group practice" and the maintenance of a "fantastic teaching hospital" are both truly valued. The importance of working cooperatively is "palpable" at DHMC, she adds. John Butterly, M.D., the other executive medical director (the two have separate areas of responsibility, but work together closely) uses only slightly different words to say the same thing. What drew him to DHMC in 1999 was the opportunity to work in an outstanding academic milieu in a "culture" that is "collegial, nurturing, and supportive." Pressed on the use of the word culture, he persists: Yes, the culture difference at Dartmouth-Hitchcock is very real. The most recent past president of the Clinic, Stephen Plume, M.D., calls it "the Dartmouth flavor."

Bird acknowledges that it is no longer possible to have quite the same feeling of personal invest-

## A Dartmouth-Hitchcock Clinic Timeline

**1927** Hitchcock Clinic is founded by Drs. Bartlett, Bowler, DesBrisay, French, and Gile; the leadership rotates among the foundering members for 16 years

**1943** Bowler is named the Clinic's first president; he holds the position until his retirement

**1956** The refounding of Dartmouth Medical School (DMS) begins

**1960** Bowler retires

**1964** Clinical departments are established at DMS, in anticipation of the reinstitution of a full M.D. program

**The Clinic's membership in 1958. Dr. Elizabeth French, the first woman member, is in white.**

**1968** The M.D.-granting program resumes at the Medical School

**1973** Dartmouth-Hitchcock Medical Center (DHMC) is established as an umbrella organization for the Clinic, DMS, Mary Hitchcock Hospital, and the VA Hospital

JON GILBERT FOX

**The Hitchcock Clinic-Concord in the early 1990s. Pictured are Drs. Philip and Suzanne Boulter.**

**1983** DHMC becomes a formally incorporated organization

**1984** The first Hitchcock Clinic facility outside Hanover is established, in Manchester, N.H.

**1985** Hitchcock Clinic is established in Concord, N.H.

**1989** Hitchcock Clinic is established in Nashua, N.H.

**1991** DHMC moves all of its clinical and some of its research and education operations from Hanover to a new campus in neighboring Lebanon, N.H.

**1994** Hitchcock Clinic is established in Keene, N.H.

**1995** The Hitchcock Clinic merges with the Massachusetts-based Lahey Clinic and becomes Lahey-Hitchcock Clinic

**1997** Lahey-Hitchcock merger is dissolved

**1999** Clinic's name is changed to Dartmouth-Hitchcock Clinic

JON GILBERT FOX

**Dr. William Boyle, pictured here in 1998, has been a pediatrician on the Clinic staff since 1970.**

**2002** As the Clinic celebrates its 75th anniversary, it counts 670 physician members—400-some at its main, Lebanon, N.H., site and another 170 at over 25 additional sites

The symbiotic relationships inherent in today's Dartmouth-Hitchcock Medical Center date from those early days. The result has been an atmosphere of remarkable collegiality—a "culture" that both attracts people to DHMC and holds them there.

JOSEPH MEHLING


**In 1991, this brand new Dartmouth-Hitchcock Medical Center campus in Lebanon, N.H., became the Clinic's home. It also houses Mary Hitchcock Hospital as well as many of the Medical School's educational and research operations. The three organizations have become ever-closer over the years in terms of planning, budgeting, and policy-setting.**

In the 1960s, it was clear that there needed to be a renegotiation of the relationship between the Hospital and the Clinic, as well as between DMS and the Clinic. The mood at times was "somewhat acrimonious," says CEO John Collins, but, in the end, "we did the right thing."

ment in the organization that used to exist; when he joined the Clinic in 1964, he was the 54th active physician in the group. Today there are nearly 700 members, so they cannot possibly all know each other. He insists that there is nonetheless an "underlying attractiveness" that brings good doctors to Dartmouth. The knowledge that they are not working in isolation but can tap the shared expertise of many minds for any patient's benefit is perhaps the key benefit to working in a true group practice. It is, according to Bird, something that "goes right back to our roots."

But though history is clearly important at the Clinic, no one is tempted to live in the past—not least because medical practice, education, financing, and politics have all become much more complex. Even as new triumphs are achieved, it is clear that standing still is not an option. "Change" has been another watchword for the Clinic.

## Act II: Productive tension

When Bowler retired in 1960, the difficult task of stepping into his shoes as Clinic president fell to internist Sven Gundersen, M.D. He was succeeded by Jarrett Folley, M.D., during whose decade of service as president the Clinic grew enormously. The increased federal funding for medicine that was available beginning in the 1960s, which helped make possible the successful "refounding" of the Medical School, also benefited the Clinic. But this was not an easy period in Hanover, medically speaking. When talk of reinstating an M.D. program became earnest, it was clear that there needed to be a renegotiation of the relationship between the Hospital and the Clinic, as well as between DMS and the Clinic. The mood at times was "somewhat acrimonious," says Collins, but, in the end, "we did the right thing."

The efforts to balance the responsibilities and roles of the various players intensified in the early 1970s around discussions to create Dartmouth-Hitchcock Medical Center—an umbrella organization comprising the Clinic, the Medical School, Mary Hitchcock Hospital, and the VA Hospital in White River Junction, Vt. (which had opened in 1938 and become affiliated with Dartmouth in 1946). By no means everyone had approved of the School's expansion, nor was everyone in favor of the medical center concept.

It was in this atmosphere that Richard Cardozo, M.D., was elected the fourth president of the Clinic. Cardozo himself implies somewhat sardonically that he got the job simply because no one else was willing to do it. But Collins identifies Cardozo as a critical figure in moving the Clinic successfully into a true Act II, everything up to that point having been, in Collins's metaphor, part of Bowler's Act I.

Still, the benefits of a formal arrangement among the institutions were not intuitively obvious. Was the Hitchcock Clinic to be an independent organization? Or would it be reduced to being a fiscal entity within Mary Hitchcock Hospital? Would the Medical School require huge amounts of teaching time for little or no remuneration? Would that time away from medical practice be detrimental to the Clinic's finances?

Some at DMS wanted out altogether, fearful that the Clinic would try to run all aspects of the clinical curriculum. This was not a new problem, as is clear in a long letter written in 1969 to Clinic President Jarrett Folley by Gilbert Mudge, M.D., who was dean of the Medical School from 1962 to 1965 and later a professor of medicine. Mudge wrote of "confused" institutional purposes, a lack of "clarification" of roles, and a need for "clear understanding" about future developments. The College archives also contain an unsigned 1972 "Special Note" on relations between DMS and the Clinic that makes repeated references to "problems" (albeit with concessions that they were not large).

The Clinic had such a strong ethic of patient care that its leadership found suspect the Medical School's increasing insistence on the need for research. In its turn, the Medical School argued that both good teaching and good clinical practice were dependent on research. Still, some remained un-

## Dartmouth-Hitchcock Clinic Locations

This map shows all Dartmouth-Hitchcock Clinic practice sites as of November 2002. In addition, there are a number of other outreach sites to which Clinic staff travel.


The give-and-take was at times a bit rough around the edges. But by 1983, the question of "who is in charge" had largely dissipated. Observers now express the view that the prolonged debates worked, in the end, to everyone's advantage. Slowly, the vaunted spirit of collaboration and teamwork became a much-valued reality.

convinced. As late as 1980, a confidential memo to the Dartmouth College Board of Trustees included a scathing review of relations between the Clinic and DMS, as well as of those between the Clinic and the Hospital.

The lack of a unified clinical faculty was the central issue. The Hospital was the paymaster for the residency programs (which then had no ties to the Medical School), and the Clinic was the paymaster for the clinical staff (most of whom at that time did not want to do research and many of whom seemed to care very little about DMS). When the DHMC board was formed, some of its members thought the Clinic members were arrogant; the feeling was likely mutual. Others, in contrast, feared that the Clinic and the Hospital had become too cozy and even suggested that the Clinic should perhaps be disbanded. Cardozo speaks bluntly of there being "considerable turmoil" during the 1970s.

Yet through it all, among the major contributions made by Cardozo during his presidency was making sure the Clinic retained a place at the table in all discussions about collaborative efforts. The give-and-take was at times a bit rough around the edges. But by 1983, the question of "who is in charge" had largely dissipated and Dartmouth-

MARK AUSTIN-WASHBURN


**Signs like this one signal the presence of the Dartmouth-Hitchcock Clinic in communities all over Vermont and New Hampshire. This one is in Lyndonville, Vt. (Sadly, this particular facility was heavily damaged by fire in mid-November, but operations are ongoing in a nearby town and there is a commitment to reopen the practice in Lyndonville.)**

The big changes—and challenges—of recent years have involved the development of Clinic sites away from the main campus. The Dartmouth-Hitchcock Clinic is now a distributed system of health-care facilities.

Hitchcock Medical Center, which had been functioning on an ad hoc basis for a decade, was formally incorporated.

More than one observer now expresses the view that the prolonged debates worked, in the end, to everyone's advantage. A better balance of power was established than would have resulted if one institution had won all the bargaining points at the outset. Slowly, the vaunted spirit of collaboration and teamwork became a much-valued reality. Even when tensions arise today, they are usually dealt with productively and creatively, according to the Clinic's current president, Thomas Colacchio, M.D. Now, he says, the shared values of cross-subsidization (based on the belief that the whole is crucial to the health of any part), collegiality (fundamental to the Clinic's identity), and commitment to the best possible care for the patient (including keeping that care local whenever possible) are firmly established.

The big changes—and challenges—of recent years have involved the development of Clinic sites away from the main campus. The Dartmouth-Hitchcock Clinic is now a distributed system of health-care facilities. The establishment of a Hitchcock presence throughout the region was not the result of some grand master scheme, however, but of a string of individual events worthy of a separate account. Behind this growth lay a belief that the Clinic had not just a duty to care for the patients who cross its threshold but a public trust, a corporate responsibility, for the health of the region in which it was located. And the further conviction that patients want to be treated locally whenever possible led to a sense of obligation to work with other communities to make the best care available there. That feeling of "commitment" to the region has been another watchword for the Clinic.

## Act III: Regional reach

Early on, the Clinic had engaged in outreach in the form of specialists working periodically (by invitation) in local hospitals—from Colebrook, N.H., to Brattleboro, Vt. In the 1970s, services such as neonatology and oncology developed into statewide resources. The Clinic also (when asked) helped medically underserved areas recruit doctors to practice locally.

The result is that the Clinic has for some years been providing a public service not only to the patient population within easy reach of Hanover and Lebanon, but to the people of northern New England generally. In retrospect, it is easy to see this as flowing from the Clinic's original mandate. It all goes back to the idea expressed in Bowler's honorary degree citation: the "blessing of superb medicine practiced by men [and women] who meet their patients as they're meant to be met in these parts, as neighbors."

But hanging a Dartmouth-Hitchcock shingle *in* Manchester, N.H., or Woodstock, Vt., was a commitment to community service on another level altogether. Physicians at all the current Clinic sites (see the map on page 37) have the full support of every service on the Lebanon campus, but they remain local doctors serving local patients (their "neighbors"), and they are not required to refer patients to DHMC.

The biggest regional leap for the Clinic, in the 1990s, turned out to be more of a lurch—though even here, in the recovery period, there have been benefits. (Collins calls this decade the beginning of Act III.) Stephen Plume, the Clinic's president from 1990 to 2000, does not hesitate when asked what the most difficult or disappointing aspect of his otherwise very successful presidency was: the Clinic's merger in 1995 with the Lahey Clinic, based in Burlington, Mass. Much ballyhooed and seemingly full of promise, the merger ended in "divorce" two years later. A great deal of time, energy, and money went into trying to consummate this marriage; in the end, however, it became clear that the bride and groom were incompatible in fundamental ways.

The word most commonly used to describe the reasons behind the dissolution of the huge Lahey-

Hitchcock Clinic is, once again, "culture." While that term can encompass a variety of factors, it seems clear that money was a significant one. The commitment to near-equal salaries that had been so central to the Clinic was not part of Lahey's history, and it was too symptomatic of the Hitchcock emphasis on teamwork and cooperation to be ignored or sacrificed.

Ask Plume what the *best* part of being president was, and he does not hesitate there either. Being in a position to help the organization become more self-conscious about its values, seeing abstractions turn into reality, and working with others to abolish the assumption that unintended medical outcomes (errors and complications) are embedded in the system and can't be avoided—these were accomplishments that he found to be rich reward for the administrative demands of the position.

To some extent, what happened after the Lahey de-merger was a recommitment to the organization's founding principles. Plume clearly believes that the long tradition of collegiality and of confidence that an individual can make a difference to patients and to the organization as a whole is critical. The 1990s were, he says, a "decade of culture change," a large-scale reaffirmation of the core values present in the Clinic's historical roots.

The 1991 move to the new Medical Center on the Lebanon campus helped a lot in that process, according to Plume (Colacchio agrees, calling the move both a catalyst for and a result of ongoing developments). Plume also believes that a higher standard than ever has been set (and is being met) for members of the Clinic. A renewed emphasis on patient-centered care and a continuing search for new and better ways to deliver health care throughout the region have been exciting and stimulating. And research, once viewed with suspicion by Clinic members, is now embraced wholeheartedly as an integral part of practicing in an academic setting. As a result, there has been some very satisfying national recognition—evidence that DHMC is on the right track.

One project that has attracted considerable attention is the Northern New England Cardiovascular Disease Study Group, in which Plume himself has been a key player. This consortium of nine medical centers has made seemingly tiny changes in process, without fancy policy statements, in the way heart surgery is performed. The unusual cross-institutional collaboration has resulted in a sustained 25% drop in mortality for bypass operations across the region—giving it, now, one of the lowest bypass mortality rates in the country.

Colacchio says the sense of accomplishment engendered by such projects makes physicians genuinely enthusiastic about coming to DHMC, not only to practice but also to train. Administrators, too, are positive about the place. CEO John Collins, for example, has been at Dartmouth-Hitchcock nearly 30 years. His commitment to and pride in the organization are evident.

FLYING SQUIRREL GRAPHICS

**Pediatrician Pamela Jenkins, on the Clinic staff since 1995, is one of almost 700 members today. She holds an M.D. and a Ph.D., practices general pediatrics (at the Lebanon site) as well as specializing in critical care recovery, and does research in the long-term outcomes of care for children born with a rare congenital malformation of the heart.**

Nor is it only the institution's leaders who feel that way. In March of 2002, an anonymous staff-satisfaction survey was conducted for DHMC by Baird/Borling Associates, an outside firm. For starters, the response rate was 93% (compared to an average of 61% on surveys the firm has conducted at other academic medical centers). In addition, 76% of Dartmouth-Hitchcock respondents (compared to 39% nationally) pronounced themselves "generally or extremely satisfied." To be sure, there is room for improvement; people across the organization feel they are asked to do too much work in too little time. But the bottom line, concluded Baird/Borling, is that it is impossible to "stress enough how different this place is from most health-care organizations." DHMC, the firm said, is "a diamond in the woods."

The Clinic's longevity and scope are both impressive. And its much-mentioned culture is obviously something to be proud of. But perhaps its most important achievement is continuous innovation. There is every reason to think that the Clinic's next 75 years will bring both continued adherence to its founding principles and further innovations—and that the curtain will rise for Act IV. ■

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