THOMAS ALMY

Dr. Fitzhugh Mullan,
interviewer

Almy: My name is Thomas Almy.

Mullan: And your date of birth?

Almy: January 10, 1915.

Mullan: Dr. Almy, if you'd tell me a bit about where you were born and where you were brought up.

Almy: I was born, and was brought up, in Manhattan Island of New York. That accounts for me until the age of sixteen, when, after a slightly abbreviated secondary school education, I went to Cornell University.

Mullan: In Ithaca?

Almy: In Ithaca.

Mullan: What did your parents do?

Almy: My father was a New York attorney, and my mother was a housewife. My father graduated from Cornell with a law degree, and almost immediately got a job in New York, and remained there.

He died when I was twelve years of age. So I lived the life of what he used to call a "cliff-dweller," an apartment-dweller in Manhattan, for most of my life, until I went off to medical school.

Mullan: Where did you live in Manhattan?

Almy: On Riverside Drive. I went to what is clearly the oldest established school in the United States, the Collegiate School of New York City, founded in 1628, which was three blocks away, and stayed with it until I went off to college. I was a member of a class of seven students in that school.

Mullan: Students who completed school?

Almy: That's the way it turned out. We were as many as twenty or twenty-five, at one time or another. But in the Depression, the people who could afford private education and the rent in New York were becoming fewer, and those that hadn't gone to boarding school elsewhere were very few. So I went from a class of seven to a class of about a thousand.

Mullan: How was Cornell?

Almy: Cornell was a lonely place, in the sense that I did not have, at age sixteen, the experience or the sophistication to become a social person in the life of that time. But I worked

hard at the courses that I took, and did well enough to get invited to apply to medical schools, and only made two applications, and took Cornell.

Mullan: What got you thinking about medical school?

Almy: I backed into it. I thought at one point that I was interested primarily in chemistry, and that I would go into pharmaceutical chemistry. A good friend of my late father took me aside one day, and said, "The first thing you should do is get your MD degree, and then decide whether you want to go into that." That was really the determining factor. I had no tradition of any MDs in the family, and the ones that my family had seen were not prominent in our lives before my father's sudden death from a stroke.

Mullan: Were there any physicians that were role models or influences for you in that pre-medical period?

Almy: Only a few. These were chance neighborly experiences, mainly at my father's weekend and vacation home in Fairfield County, Connecticut, where the man across the street was a family practitioner, and on the other corner of the four corners on which our house was, one of the other corners was the summer home of a gynecologist from St. Vincent's Hospital in New York. My father died in our home up there in Connecticut, and the family physician on the other corner was the only person who saw him in

the thirty-six hours that he survived after we arrived there. He, by any standard we could judge now, was totally ineffective in this. So I can't trace my interest in primary care to my childhood experiences at all. This was all developed at a much later date as a result of various events in my medical education.

Mullan: At Cornell, it was a lonely place. It was a place you made the decision to study medicine, after you had developed, I presume, an interest in chemistry. You were inclined towards the sciences?

Almy: I didn't know what I was inclined towards, at age sixteen, except to continue to do what I should to be successful as a student. I knew that I needed a basic education, so I studied arts and sciences, in a broad sense. I didn't get very deep into any of them, but I knew that I would want a scientific background, which Collegiate School had not satisfied at all. So I took physics and chemistry, and went to organic chemistry before I realized that it might serve this special purpose.

Mullan: Were you a chemistry major?

Almy: Yes. I still get literature from Cornell on that theoretical basis. I was a chem, plus biology major, which was the closest they came to defining a pre-medical.

Mullan: When you reached the end of college, you were considering medical school. You applied to two places?

Almy: Right. Cornell and Columbia. I had been called to an interview at Cornell, and got their acceptance of me a couple of days after I got back to Ithaca. The next day, I received an acceptance from Columbia, sight unseen. That's how different the admissions process was in those days. Because I saw Cornell as a source of continuity in my life, and it had been my father's alma mater--incidentally, I was in the house of a national fraternity that my father had been president of, so that I was a legacy to them. Everything had been kind of channeled. But I was excited by the newness of the medical center at Cornell.

Mullan: When had it been built?

Almy: It had been opened in 1932.

Mullan: And you would have been entering in 1935?

Almy: '35. And was interviewed there early in that year. It was, of course, a very hectic time for the New York Hospital, because of the Depression having deflated their financial reserves.

Mullan: Was that palpable as a medical student?

Almy: No. I was aware that it was happening, that there was some turmoil within the faculty, but it didn't affect our education.

Mullan: And how about in terms of your own family, and family finances, both for college and medical school?

Almy: They were razor-edge. It being the Depression, I'm glad we didn't have to sell the little bit of real estate that the family owned, because it has since multiplied considerably in value, but not enough to enrich us. The tuition being something in the order of $400 a year, that was not the problem but the other expenses of living were burdensome.

Mullan: Did you live at home, or did you live at school?

Almy: I started figuring out how to find an apartment near the New York Hospital in Manhattan. My mother had decided that there should be a room there for her, and we took in a couple of my classmates as roommates. So that's the way it worked for the time I was a medical student. It was right across from the Rockefeller Institute, and very convenient--walk up, that kind of thing.

Mullan: Were you an only child?

Almy: Yes.

Mullan: How did you find the medical school? How were the studies of medicine then?

Almy: Well, for the first time I felt I was at the center of the action, intellectually and socially, instead of way out on the periphery, and this had a very stimulating effect on me. In the Collegiate class of seven, I had been drawn out of the cocoon by being appointed the editor of the yearbook, and made some innovations in that. Since nobody else was trying as hard as I was, I was the valedictorian, and that kind of thing. But I never felt that I was really living in the center of the action, going into the medical school.

Mullan: And why was that? What about the medical studies?

Almy: Well, everybody was working hard. My classmates, fraternity mates, at Ithaca had been playing bridge every night while I was working away through pre-medical subjects, and the social ineptitude from which I suffered at age sixteen to eighteen began to become less of a problem in medical school.

Mullan: What were the studies of medicine, both pre-clinical and clinical, like at Cornell at that time?

Almy: In the first two years, very formal and didactic. You know, all about anatomy. You've heard about the older teaching of anatomy. Well, it was true. The place where it began to

change was in pathology and in microscopic anatomy, when we were coached rather closely by people, at our microscopes. And we were even drawn into groups who would be assigned, or elect, minor research activities and make reports. So this began to stimulate the feeling that you were really collaborating with faculty and developing a sort of tutorial relationship with them.

Mullan: What were the clinical years like? Did you do all your work at New York Hospital, or were you farmed out elsewhere?

Almy: I did everything at New York Hospital. There wasn't much in the way of elective assignments elsewhere. There was only one formal month, as I recall, in all the four years, which was strictly reserved for elective work in rotation, and that was an elective at Memorial Center, which moved from Central Park West to York Avenue during my our junior year.

Mullan: And Memorial was cancer?

Almy: Yes, oh, indeed. It was the first cancer hospital in the country, I believe. Memorial Center, of course, multiplied its endowment and its aspirations developed the Sloane-Kettering Institute shortly thereafterwards.

Mullan: Being entirely a private institution, were you allowed to work with private patients, or did you see clinic patients, or how did that work?

Almy: We saw clinic patients. Otherwise, our assignments were on the wards.

Mullan: By "clinic patients," I'm not sure what distinction we're making. Were these poor patients who were seen at Cornell?

Almy: The clinic in those days was one which you could call a not-for-profit intraservice operation, a provision to take care of people for little or nothing, if necessary. It usually tried to transfer people. It could only be costly because of the usual reasons. But the fees were minute, even by Depression standards. The standard of care was, from the point of view of the doctor-patient relationship, a pretty rigorous and rather progressive one.

I was called down rather vigorously one day by Dr. Paul Reznikoff, the director of the Outpatient Department, because in his hearing, he thought that I had called the patient from the waiting area without prefixing it by "Mr." So-and-so, and he really started to lay into me because I was offending that man's dignity. I'm sure in many other institutions that would not have been noticed at all, if it had been true. But I managed to persuade him that I had indeed said, "Mr. Goheen," or whatever it was.

Mullan: What were your classmates like?

Almy: I think that your father and I were pretty average. I don't know enough about his forbearers to compare our backgrounds, but the place was beginning to be appropriately diverse in the mix of its students. It had gone through a period of rather severe criticism, and had been labeled by other schools and other people with axes to grind, as anti-Semitic. And that attitude was quite prevalent among the older staff of the New York Hospital, but the school had been wise enough to move away from that, though slowly. I thought the most vigorous effort to move away from it was in the Department of Medicine, and specifically with the leadership of Eugene Dubois, who was the man I came to idolize.

Mullan: So as you finished medical school, what were your thoughts? What were your plans?

Almy: I'd do better to describe first my experience of clinical teaching at Cornell. In the Departments of Medicine and Pediatrics the word was not, "Someone should teach you about this," but you, the student, were responsible for digging out the facts from original literature sources, and asking the right questions, and getting into discussions with faculty at the bedside. This really got to me, because I felt my security had rested on my ability to memorize what I had learned in textbooks, which had served me well up to that point, and I had a panic in the middle of the third year. But the sense of self-realization that came to me when I began to see that this was working has

been a factor that gets to me even today. I can show you how I have expressed it in various ways.

I started in my fourth year, having had, in the summer preceding, a surgical externship, in which I was in the operating room much of the time, and I was given more responsibility than I had received in any of the other departments before then. In the fall of the fourth year, I arranged a little time for a little tour of a few hospitals, and I talked to a number of people about residencies in surgery. Then I started the course in obstetrics, and found that I was getting even more responsibility and there was much more human interest in the problems of bringing babies into the world. You know that both your father and I delivered babies in Harlem, in tenements.

Mullan: Tell me about that. So your entire medical education wasn't in New York Hospital?

Almy: That's right. I was making a generalization.

Mullan: Tell me about Harlem.

Almy: But I mean, we were not in other hospitals. I could have had an elective at Bellevue, but I didn't take it because I was getting along pretty well with the things that interested me.

Mullan: Tell me about the Harlem obstetrical experience.

Almy: Well, there was a free clinic, the Berwind Clinic, named after a tycoon in the coal industry, on 103rd Street and Park Avenue, near the New York Central tracks. This was staffed by the residents of the Obstetrics Department, with a tiny bit of senior supervision, and a rotating cadre of fourth-year students. We were there for two weeks at a time. I think I had about an average experience there. I had something like eleven to twelve deliveries that I was responsible for. All these mothers had been enrolled in the first trimester, were followed in ideal fashion, I think.

Mullan: At the Berwind Clinic?

Almy: At the Berwind Clinic. We did not screen the patients. The residents screened them. If they found something that required a lot of attention or if the woman was a primipara, they'd send the patient to New York Hospital for care.

Mullan: But the others were home deliveries?

Almy: The others were home deliveries, and these were assigned to the students in rotation. The patients were served also by the Henry Street nurses that followed them during pregnancy.

Mullan: So you had nurses who worked with you?

Almy: They were not necessarily there, but we would handle the delivery.

Mullan: All by yourselves?

Almy: With the other members of the family that were present.

Mullan: But you were the only medical person?

Almy: I was the only medical person, although I could get the resident or the nurses there.

Mullan: If you were having trouble?

Almy: If I was having trouble.

Mullan: Did you?

Almy: I think I only once had to call for assistance. These people were so well-screened that the deliveries went smoothly.

Mullan: Where would you deliver? In the bed?

Almy: In the bed, yes. They had elaborate--this is going into detail which probably is beyond the purposes that you have--but the family had elaborate instructions, all laid out, and coaching

by the nurses, so even though they were not terribly intelligent women, they knew what to do.

Mullan: What sort of population? Was this a black population?

Almy: It was about, I would say, 60 percent black, 40 percent Hispanic. And it was a sociological experience. I mean, for sociological exposure, it was fantastic.

Mullan: Which was different than much of what you'd experienced at New York Hospital.

Almy: I'd seen plenty of patients of multiple ethnic groups there, but not the concentration on the poor, the disadvantaged, and the ways in which those different family constellations operated, the different beliefs that one had to contend with and so forth. It was all very exciting.

Mullan: So that had an influence on your fourth year?

Almy: It did. Since I'd had about fifteen deliveries before that at the lying-in, by the time I was through at Berwind, I had had nearly thirty deliveries that I had personally attended. Suddenly it occurred to me, this would be a pretty boring way to spend the rest of my life, and I began to consider the values that I had seen in a lot of the activities of the Department of

Medicine, and abruptly decided, "That's for me." I was fortunate enough to be chosen for the intern staff of New York Hospital.

Mullan: Just to take a brief aside on what, as well as you remember it, your graduating senior student colleagues were thinking, were most of them thinking about residency training, in terms of a full residency training? Were many thinking about doing one year, and going into practice? What was the norm for your class?

Almy: I'm quite sure the norm was for more than one year. I am sure of that. I'm not sure that many of us had a clear idea, of the full extent of graduate training such as today's graduates have. But, yes, we knew that the good places were going to hopefully employ you for three or four years, and you just had to do the job right. There would be a place for you there.

Mullan: Was the notion of becoming a general practitioner entirely discredited at this point, or were there people who were, in fact, proactively thinking they wanted to be GPs?

Almy: I think this was not a common feeling of that class. I think we all had some idea about a career within medicine, which would make us less of a generalist than that. The image of internal medicine as being generalist enough was already in our minds. Those who were not attracted to specific other fields would tend to gravitate to, and having been exposed to a high-

class undergraduate atmosphere, with a good deal of science base and individual stimulus to excel, I think few of us would have taken on a one-year internship. I don't think any of us did.

Mullan: So you went on into internship at New York Hospital. Internal medicine, or was it rotating?

Almy: No, there were no rotatings. That was another message to us. There was no rotating internship there. I guess there were some mixtures of departments. Maybe there were a few folks. I haven't given this any thought, actually, in recent years. But I don't recall anybody having anything more complicated than a mixture of surgery and pathology, or medicine and pathology.

Mullan: What bearing did the war have? I'm thinking there must have been a sense of impending militarization.

Almy: We certainly were working in that atmosphere.

Mullan: This was 1939.

Almy: Right. But until the U.S. got in, there was not enough pressure to force us to plan for military service.

Mullan: So most people continued into their training knowing that there were issues, but not rerouting their careers?

Almy: That was my impression.

Mullan: So tell me about house officership. What was that like?

Almy: Well, it was really an extension of the experience of the clinical department of medicine at Cornell, because it was all there. The internship and residency were located there.

Mullan: Did you do a three-year?

Almy: I had two years of assistant residency and a year as chief resident.

Mullan: After the internship?

Almy: After the internship.

Mullan: You had four years. And what were you thinking as you went through that, in terms of your life work? Were you thinking practice, academia? What did you have in mind?

Almy: I was thinking of what we would now call a scientifically oriented clinician, with emphasis on institutional care and teaching and research. My capacity for research, I recognized, was quite limited, and I never successfully got focused on it, nor spent even a year in solid dedication to a single protocol, so that I was not developing the background by which a scientist

is usually measured. This was, in part, because of the accelerated demands of clinical medicine in war time, and the limited number of opportunities that I ever heard about. To drop everything and go elsewhere, to get a focused education and a focused experience in some fellowship-type field, those opportunities were not very common on the horizon. So I just went through the prescribed rotation, which was all at the New York Hospital, with a sense of great *esprit de corps*, great admiration for my associates and for the people that I worked with, and came to know by their first names, as junior attendings, and so forth.

Mullan: And then what happened?

Almy: When Pearl Harbor came and the New York Hospital--Ninth General Hospital was being organized, I applied for a commission. I was right then in the middle of the most significant illness of my early years. I developed a quite obvious sciatica, which was quite painful, and I wandered around with a cane. Nobody knew at that point what we now know, that most of those are due to prolapsed herniated intervertebral discs, and my second year of assistant residency was kind of botched up by that. But I managed to do what was expected of me, with some difficulties. The military denied me a commission, and the result was, in June 1942, the Ninth General Hospital, was spun off without me. And that was the month before I began my term as chief resident, which, because of wartime pressures to maintain the largest

possible residency staff, I was only allowed six months of that role, although officially I was always recorded as having finished four years of training.

Mullan: So the General Hospital spun off a large number of the staff who had been commissioned with it?

Almy: That's right.

Mullan: They were deployed in the field somewhere?

Almy: I was literally the only one of my group of interns that was left behind at the New York Hospital.

Mullan: So the staff was stretched quite thin, I would think.

Almy: Yes, it was.

Mullan: But you continued on.

Almy: I continued on as chief resident. Enjoyed it to the fullest. It was a fantastic experience. Meanwhile, Dubois had departed as chief of medicine because of some squabbles within the senior faculty. The heads of other departments were cutting up, and he was unjustifiably embarrassed in the efforts that he was trying to make to continue a certain standard. He moved over

to physiology, and David Barr took over as chief, and he was our second boss.

Mullan: And did you stay on, then, as a junior attending, when you finished?

Almy: I did. Dr. Barr had plenty of jobs for me in the year after I finished the residency. The second six months of that year, I had gone to the Army Medical School to study tropical medicine, because nobody knew anything about tropical medicine, and the military demanded it. After two months there, I came back and started teaching it.

In the summer of that year, I went to Central America for field experience and did that job for four or five years after that.

Mullan: Back at Cornell, you were?

Almy: Yes.

Mullan: As you approached your now real work, in the sense of having finished your training, what you had in mind, how you saw yourself, and where you were headed, and what you did.

Almy: I felt it was my duty to do everything I could to help hold the fort back there. I admired Dr. Barr a great deal and what he was trying to do, and understood what he was up against,

in terms of recruiting other manpower and so forth. So in the course of the year, I was appointed the chief of teaching of tropical medicine. I continued the work that I had begun as chief resident, as being a cardiac consultant to the obstetrical service. I continued the interest that I had developed personally in diabetes and some aspects of endocrinology, particularly the menopausal syndrome.

Late in the year, I was asked to take over the gastrointestinal clinic, the then-director of it having suddenly had a myocardial infarction, and resigned. So I was a jack-of-all-trades.

Mullan: This was now '44, '45?

Almy: This was the fall of 1943. Incidentally, I had gotten married in that year.

Mullan: Give me a trajectory of your life--the war years and the post-war years. I gather you stayed at Cornell.

Almy: I did.

Mullan: Give me a kind of fly-over.

Almy: I remained at Cornell, in slowly ascending rank and never-ending responsibilities, until 1968, when I came up here. But the first year, after the 1943-'44 year, was the most busy, in

terms of new commitment, and it was a time of making do with what one had in the way of personnel and other resources. I was assigned an office which had an old typewriter in it, and that was it. I was working in a G.I. clinic that had an abundance of patients who were there for irritable bowel syndrome and nothing else, practically, because the surgeons took over everything else, and anything that looked as if it might require an operation. But I discovered that they later needed consultation when the results of their operations were unsatisfactory.

[Begin Tape 1, Side B]

Mullan: This is Dr. Almy, side two of tape one.

In the period of your immediate post-residency training, given the exigencies of the war, among other things, you were called on to perform what in latter years would be called specialty or consultation kinds of activities, and yet your training was, at the time, as a generalist, or an undifferentiated internist. And indeed, in that post-war period, ranging from '45 to '68, there was an enormous tendency towards specialization and sub-specialization. How did that play out for you? Did you continue to be a jack-of-many-trades? Were you ever tempted by formal specialty training? And how did you see that development, both personally and institutionally?

Almy: Well, my problem, and my opportunity, was that I picked up a number of responsibilities in this wartime period, where my

physical disability had left me out of the military. I had accepted responsibilities assigned me, and seemed to enjoy them, so that I went with the flow and managed to teach myself.

Gastroenterology. An example of the kind of thing that bothered me was that I knew there was a specialty board in gastroenterology, but I knew I could never pass the examinations because I hadn't boned up on all the things that they would be wanting to ask me about. If these hadn't come on my plate as a clinician at the New York Hospital, I would probably have to draw a blank on them.

Mullan: I'm sorry. I'm having a little trouble with the tape, but I think we're working all right now. You were saying about your decision not to formalize your specialty in gastroenterology.

Almy: I felt that I would have to interrupt too completely responsibilities that I already developed at Cornell, and I was uncertain how much I would learn by moving away at that point. I had no one really around that would advise me. There was no other academic gastroenterologist to turn to and the clinic staff had had no such experience of fellowship training.

Mullan: Give me a thumbnail of that period. You've described gradually ascending positions. Did you spend your time clinically in teaching and administration? How did your time divide out for that whole period?

Almy: All of the above. [Laughter]

Mullan: What were your emphases?

Almy: The emphases were teaching, and the load of clinical responsibilities that I'd been assigned. These evolved into clinic work and specialty consultations. I would, for example, have a cardiac clinic, a gastrointestinal clinic. I would respond to consultation requests in those fields and in tropical medicine.

Mullan: So you were an all-purpose teacher, really, within the Department of Medicine?

Almy: That's right, that's right.

Mullan: Largely teaching students, or house staff, or what level did you focus on?

Almy: Students and house staff. And arguing often with the people of other departments, up to the chairman, about things I thought we could improve. But the fact that I was being allowed to assume these responsibilities made me feel that I still could manage to wind my way into the field that I was coming to be most associated with, which was digestive disease, even though I was not formally educated in that field. I would never advise

anybody to try to do this today, but the opportunities were not numerous. Their quality was unknown.

Mullan: Did you have a practice of your own, with patients?

Almy: No, no.

Mullan: So you were entirely medical-school-based.

Almy: I was. I did see a fair number of private patients at the New York Hospital, but not many.

Mullan: In general medical issues?

Almy: In digestive disease, for the most part. I also got a few endocrine patients, because I'd learned enough about thyroid disease.

Mullan: And did formal teaching roles, deanships, or the like, appeal to you? Was that something that was of interest?

Almy: I never really got interested in deanships, although I went out and was interviewed for a couple of posts of that nature. I enjoyed the direct teaching responsibility. Nevertheless, I had administrative roles, in the sense that I was constantly being asked to be a member of, or at times a chairman of, one of the standing committees. At one point, I was

appointed the director of education in cancer for the New York Hospital Cornell Medical Center, because a grant was available to support that kind of thing. That was arranged with the understanding that I would chair a committee, of which I was the junior and the least powerful member. It contained department heads and the dean. [Laughter] But I was responsible for making this committee work. So I kind of fought my way through that jungle.

Mullan: You lived through what, in retrospect, some characterize as the halcyon period of growth in medical education, growth in American medicine, and you did it in the center of a very important leading institution. Some of those developments, in terms of the level of specialization, the expense of care, the maldistribution of physicians, have come under latter-day criticism. As you reflect back, looking now at the Cornell period, up to 1968, what do you feel? How would you characterize what you were seeing and feeling, in terms of the overview of the growth and directions of medical education, undergraduate and graduate, and how, looking back on it, do you assess that today?

Almy: Well, I had the feeling that Cornell was a little slow in developing the true scope of sub-specialty and science-based education for people at the fellowship level, that not enough time and organizational effort had been devoted to making that happen, to keep pace with other institutions. I think it was

because of the distance of the medical school from the parent university.

Mullan: That is, the science link wasn't as intimate or as powerful as it might have been?

Almy: That's right. And I feel that, having fallen behind in that, that Cornell's delayed efforts to catch up with that bandwagon were being impaired. So when I got the opportunity in 1954, in fact, I was asked to take another position, without dropping anything else, namely, the directorship of the Cornell Medical Division at Bellevue, I accepted it as another challenge that would free me from the trials of the New York Hospital in trying to adjust itself to the new wave of sub-specialization and the like, and to run my own show. And there, by that freedom, by the fact that I knew some of the brighter young people that were coming along, and were ready for fellowship-level training. I had begun to work for the National Institutes of Health as a study section member in cancer and in G.I.

I got out on the limb of raising soft money for special purposes, and recruited about twelve bright young people to work in the division at Bellevue, on about 5 percent hard money and a continuous struggle. Only very recently did I see a curve of the adjusted value of resources for health care research in the United States, and I realized that the year that I finally gave up Bellevue and moved up here, I had lived through to the actual

peak of inflation-adjusted value of opportunities, the abundance of opportunities to fund things on soft money.

Mullan: That being that the sixties, late sixties, were the peak?

Almy: Yes. That's official, I think, with the National Academy of Sciences.

Mullan: In going to Bellevue, you were working in a different patient milieu.

Almy: I was indeed.

Mullan: City patients, city hospital. That, as I recall, was a time that there was a formal effort, New York-wide, to connect medical schools more intimately with city hospitals, for the purpose of upgrading services. Did that take place? Did you see that?

Almy: That came about midway in my period there. I was there for fourteen years, and I think that it developed around 1960.

Mullan: That is, the formal--

Almy: The formal affiliation of other hospitals. So when there came to be intimations that the city would rather have Cornell

move out of Bellevue, I actually started visiting other city hospitals and exploring the options on my own. But I never was backed in that by the medical school. I think we could have taken over all of Queens for the asking at that point and developed that borough as an educational resource for Cornell, but the medical school wouldn't have it.

Before I went to Bellevue, and in the course of this period that you speak of, '44 to '64, I was apparently succeeding fairly well in digestive disease. I had attracted a number of young people as fellows that have turned out to be very important in the field and they stayed on for a while at the New York Hospital.

Mullan: So as you reflect on the growth of specialty medicine, specialty training, over that period, you feel that Cornell was a little slow in getting started, but once started, and to the extent you were involved in it, you felt positive about it, that it was good development and that it developed pace after that?

Almy: Well, I think that Cornell has given a great deal of support to research in recent years. This was always very selective, always confined to the New York Hospital. I got practically no encouragement in this development at Bellevue. I got to the point where the students were preferring to come to Bellevue, as compared with having their clerkship at the New York Hospital, in medicine. We were getting every bit as good, and sometimes better, interns and residents at Bellevue, more people

being elected to scientific societies and more research grants. But I was left with the thought that Cornell just didn't like it. The only large private donation that came to me, unsolicited, while I was down there, they cursed me for it, rather than congratulated me. So I knew that the atmosphere was a hostile one, and that came at a time when, by all of the national standards, I was being pretty successful. I was president of the American Gastroenterological Association, a major factor in its growth and its orientation to national needs, and a few other things that made me feel good when I was away from Cornell, and unwanted when I came home to 68th Street.

When, in 1966, the city pressed Cornell and Columbia to remove themselves from Bellevue Hospital, Cornell didn't bother to tell me that this was happening, and I found out when while I was at a medical meeting that the story was on the front page of the *New York Times* that day. I decided that this was a signal to me to move. I made all kinds of trips around the country to look at other positions that people were interested in me about, and finally, after many dry taps, I liked what they had to say at Dartmouth, although it was easily the most poorly funded of the opportunities that I had considered. All that was no closer to primary care than the work of a general internist, which is the only thing I'm certified in. And I, myself, with no experience of delivering primary care, except in the spirit of broad responsibility for the patient who comes to see you in a clinic. But when I came up here--

Mullan: Which was 1968?

Almy: That was 1968. I accepted a job that was defined as the chairman of the Department of Medicine by the medical school but not by the staff of the hospital and the Hitchcock Clinic, which is full-time in the hospital, as I guess you know. They wanted to call me director of medical education. When I said, "Thanks, but no thanks, then I'll go back to New York City," they started negotiating, and I was eventually induced to sign on because I liked the academic prospects at Dartmouth very much, and the opportunity to work with something that was really in its infancy, I accepted the title in the hospital as director of medicine for the Dartmouth-affiliated hospitals. Every time that that title was mentioned by the chief of staff of the hospital, he would add, "Whatever that means." And what that meant was what he thought it meant. It was up to me to fight my way out of that.

Mullan: Medical school, at that point, was just two years.

Almy: That's right.

Mullan: So you did carry the title of chairman of medicine?

Almy: Yes. At that very moment, Dartmouth was realizing that the life of a two-year medical school was going to be strictly limited. I don't know whether there are any left, but Dartmouth

was one of the last. The reason it was so predictably about to go was that the Johnson Administration was offering money in support of medical education. A few new medical schools were developing, or the old ones were expanding.

Mullan: It was a national time to expand.

Almy: So it was a national time to expand, and that's one of the reasons that the medical school buildings here in Hanover are twice as large as they were when I arrived, because that was part of the bargain.

Mullan: When did the school actually open for the third and fourth years?

Almy: Let's see. The first class to graduate was 1973. The faculty decision to develop a third year of medical school was taken four days after I arrived, in March of 1968, and the pattern developed rapidly after that. I was the second of the clinical departments to have a department head, since psychiatry had had to be developed totally independently from the Hitchcock Clinic. They had not seen fit to incorporate that into their structure, though there was already a professor of psychiatry.

Mullan: So that must have been exciting. You really were in on the ground floor of expanding it.

Almy: Yes.

Mullan: And your energies, I gather, for the first few years, went into developing a curriculum for the third and fourth years?

Almy: Right. With some very great colleagues that made it very enjoyable. The battle was over the governance of the place, and has continued to date, but with better success and satisfaction as the years went by. The business of introducing the students, in view of their small numbers at the time, was not onerous. It was possible to introduce them into the two hospitals we had, and to lay down ground rules for the conduct of the house staff and the work of the attendings, which were acceptable.

The other big problem was in the recruitment of additional clinical personnel, clinical professors, because the clinic was determined not to have their prerogatives in the use of hospital beds limited by people whose fundamental purpose was academic. They wanted people who were constantly available for the purposes of a group practice, and such people would not have been able to advance the group.

Mullan: So, constant tension between the practice mandate and the teaching mandate.

Almy: Right. But that went along reasonably well. I had five or six other people hired by the end of my first year here, and we got the Chair of Surgery the next year, and the Chair of what

we called Maternal and Child Health the year after that. All three of us here, understand, were Cornellians, one way or another. Dick Karl, the chief of surgery, was the head of the Cornell Surgical Division at Bellevue. I sat around here and bit my lip until the other members of the committee discovered him, because I knew that I had already generated enough political demerits here to ding him if I was the one who was pitching for him. But it worked out.

Sol Blatman had been a resident in pediatrics at New York Hospital, a resident in medicine--yes, both medicine and pediatrics, and just a marvelous choice for maternal and child health, which also indicates one of the origins, I think, of the generalist view here, that in that early stage, the medical school wondered whether they could manage to support and fund a tiny Department of Pediatrics, and a small obstetrics and gynecology faculty, from the academic point of view. So I suggested that we combine them into a single department and focus on the normal birth process and the normal span of the health of women. Sol got quite a number of speaking engagements, going around and describing what had been done here.

Mullan: Give me a quick sort of thumbnail of developments between 1968 and the present. You saw to the birth of the Department of Medicine in the medical school.

Almy: I lasted only six years in that job, '68 to '74. The years '71 to '74 were all a time of great turmoil over the

governance thing. Great indecision on the part of Dartmouth, whether they really wanted to continue with the medical school. Jim Strickler, another Cornellian, was then the dean. The finances were very fragile, and the board of trustees of the Dartmouth College was unhappy. But during that time, the thing, nevertheless, went ahead, slowly, but I got enough political negatives in the course of fighting for it that it was decided that I needed to step down. I was awarded, in effect, a university professorship, called the Third Century Professorship of Medicine, with the understanding that I would devote my time more intensively to educational ventures.

At this precise time, '71 to '73, the practical issue for Dartmouth Medical School was how to teach ambulatory medicine. The clinic had decided that they were a group of specialists seeing patients referred from all over New England, and they couldn't intrude clinic patients into this thing without losing a great deal of money. So the idea took shape of developing an ambulatory clinic experience that's focused on the Veterans Hospital and on the idea of wedding it to public health and preventive medicine.

We had acquired a chairman of the Department of Community Medicine, so labeled, late in '71, and he set out to make friends with physicians all around northern New England, in private practice, either solo or in small groups, in small towns, and counted on the students and their budget for gasoline to do the job that way, to revive the old preceptorship thing, but with greater academic connections and model-building.

I thought this was very exciting, and I brought on, actually, the predecessor of the chairman, who worked at the V.A., and we developed right away our first experience in teaching physician assistants, and the tradition of including physician assistants and nurse practitioners in the care of ambulatory patients at the V.A., which was modeled very quickly by this person, whose name was Bella Strauss, and by John Wasson, when he returned from his time as a Robert Wood Johnson clinical scholar, and took over the V.A. Clinic as the main locus for his demonstrations of model ambulatory care.

Mullan: When would this have been, about?

Almy: 1978. Right away, he and I developed the first model here of changing the curriculum to focus attention on one-on-one doctor-patient relationships in primary care, by putting it first in the curriculum, the very first week of the first year. We did this one year on an elective basis, and it was almost immediately oversubscribed. That is, we invited people in a week ahead, or maybe it was two weeks, of the formal start of the first year. We had enough room for about twenty people, and I think we had thirty-five. So it caught on very quickly. We taught them the elements of talking to patients, doing blood pressures, looking at eyegrounds, and all that kind of thing, and they were thrilled. This has progressively developed to a rather broad introduction for most of the first two years, very part-time,

while the basic science teaching is going on. We introduced them to the generalities of medical care.

It spawned a variety of other interests, stimulated a number of other interests, other people in connections with medicine in the hinterland, most notably, I think, in the Departments of Psychiatry and Pediatrics. The Children's Hospital at Dartmouth is the natural outcome of this, but it also includes the barnstorming of a range of medical specialists from here, which really reflect the way in which Nathan Smith himself served this region.

Mullan: Who was Nathan Smith?

Almy: He was the founder of Dartmouth Medical School in 1797, and he was a family practitioner who had had only a preceptorship with a rural physician over in Vermont, until he heard about the Harvard Medical School, so he left his practice and went for a year to Harvard Medical School, then came back, and started applying what he'd learned, and then asked the Dartmouth trustees if he could set up to teach medicine at Dartmouth when he returned from another break in his practice that he had decided would take him to Edinburgh and London, which he did.

The trustees made it clear that this was going to be perfectly all right, as long as it didn't cost Dartmouth any money. He was going to have a room to teach the medical students in. And so it started in 1797 as, I believe, the first and maybe one of the only medical schools in the U.S. founded by and

operated by a family practitioner, although he was quickly recognized as a home-grown genius in surgical techniques and surgical discipline. He did the second removal of an ovarian cyst in America, after the one in Kentucky, and under the same kitchen-table kind of circumstances.

Mullan: The latter part of your career, I gather, was devoted to medical education, in large part.

Almy: Indeed.

Mullan: And integrating primary care teaching throughout the medical school? But you remained based in the department of medicine?

Almy: I've never been considered the integrator of primary care teaching, but I think I've contributed to it in a variety of ways. As soon as the Department of Community Medicine was formed, the onus on the teaching of primary care was shifted to the ambulatory arrangements with family physicians that had already been established by the Department of Community Medicine. The job was left to them with the single exception of the involvement of both medicine and surgery departments at the V.A., and indeed psychiatry at the V.A., where the experiences were more clearly integrated with primary care needs than they were here in the inpatient activities of the Hitchcock Clinic and hospital.

The way in which I was able to help was mainly through educational programs, and I probably will think of another one in a moment.

Mullan: You retired at what point?

Almy: I retired in 1985, having spent the last three years off the Dartmouth payroll as a physician, a so-called distinguished physician at the V.A. They had a national program to put retirees in late full-time obligations to V.A. hospitals.

Mullan: Let me just change the tape here.

[Begin Tape 2, Side 1]

Mullan: This is tape two, side A, or the first side, of Dr. Almy.

We're talking about your career as a whole. Was there something else you wanted to add at that point?

Almy: Yes. I was dedicated to the idea of bringing medicine and community medicine together, and I think the most important thing I've done for Dartmouth is to persuade them, in looking for the new Chair of Medicine in the late eighties, to appoint a person whose fundamental interest lay in primary care--Harold Sox, a former chief resident here. He was very instrumental in education, in decision-making in the training of primary care

attitudes and skills at Stanford, was a member of the faculty of the combined Stanford-University of Cal-San Francisco Robert Wood Johnson Clinical Scholar Program, and already very well known in his field for instruments in the measurement of the effectiveness of therapy. He's been very much involved through the Institute of Medicine, of which he's a member, in the evaluation of preventive medicine in recent years.

Mullan: It's been a good development.

Almy: And he is one of the few people whose whole career has been focused on these general aspects of medicine.

Mullan: Clearly, in recent years, these broader integrative themes--medicine and primary care, public health and medicine, community medicine and medicine--have been more important.

Almy: Right.

Mullan: How did you come about what would seem like an epiphany, or a mid-course, mid-career change in focus, realizing the system is changing, not you, alone? What was that all about?

Almy: Well, I don't think it was so much, as you imply, so much of a change of attitude of mine, as a seizing of another opportunity to express what I was really interested in, which was the interpersonal aspects of medicine and the general obligations

and talents of the doctor. One of the results of my getting the job with Chair of Medicine up here was that I really couldn't work my way into become a model myself in the modeling of the care. I rarely had any but a consulting relationship to the staff up here in Hanover, and so I valued the opportunity to help shape this other thing, and I found a number of ways of doing it.

I got to the Dartmouth College undergraduates who were interested in health careers with a program of field experience, before they went to graduate school, to medical or graduate school, which would introduce them to the whole experience of relating to patients in a responsible role, so they would see the patient as a, and the whole individual before they concentrated on the disease, or the organ, or whatnot.

I took the only sabbatical in my life at Stanford for six months in 1980, and devoted it to the study of the doctor-patient relationship. This was in the Center for Advanced Study of the Behavioral Sciences, and spent a lot of time with an economist out there, Victor Fuchs, who has been very important in the economic view of the health care system and what's wrong with it. I argued with him over the role of the primary care physician, and expressed strongly my views about the inequities of the pay scales for specialists versus primary care docs. So I got wound up enough to publish a sounding board in the *New England Journal of Medicine* on some other characterizations of the role of the primary care doctor.

Mullan: What was that entitled?

Almy: The one in the *New England Journal* is called, "The Role of the Primary Care Physician in the Health Care Industry." What I'd like to do is to send you a copy of it, and you can read it.

Mullan: I'd be very interested.

Almy: And then I wrote one on the primary care physician as patient advocate, because I thought the continuing trusteeship role of the physician was underestimated. Meanwhile, Dave Rogers, the then-president of the Robert Wood Johnson Foundation, had written an article in which he described primary care as the "loss leader of the medical industry." I thought that was a pretty powerful statement, and I argued with people about this constantly, that they should accept that fact and should do what any industry does with a loss-leader arrangement, to expect it to be a loss for them, in order that they would gain the advantages of people understanding the value of the things they could offer them.

Mullan: In your words, what is "he" to primary care? Why is it so important? Why have you taught it, practiced it, preached it?

Almy: Because every patient must feel that he's trusting somebody who knows about him, who's prepared to follow him, who won't drop him because he just is getting ho-hum about what is now bothering him, and because the whole profession is less likely to be trusted if those expectations are not met. I've

been really thrilled to find so much of the Dartmouth Medical School message being packaged around this one thing.

Mullan: Was there a time in your career when the concept of primary care suddenly came alive for you, or suddenly moved front and center for you?

Almy: Well, I guess it was always there, because this was my view of what you did when you accepted the responsibility for caring for a patient. It works for digestive disease patients just as well, but they don't do so well if the focus is entirely on instrumentation and episodes of illness. I was long ago interested in the phenomena of psychosomatic medicine, and I devoted most of my early research to that, and this showed that the mind-body relationship was real. I did a pretty good job of documenting the reality of it in certain aspects of digestive disease. I think this is what is threatened today: the acceptance of the human relationship that provides security to patients and enables them to accept and value what you could also call a fiduciary relationship. I've often compared it with an investment advisor. I don't want one who's dependent on persuading me to buy something that he's selling. I want one who has decided what my needs are, and is willing to keep advising me to realize the goals we've agreed upon. That is the kind of physician I feel everyone should have.

Mullan: As you look back on your career, in terms of your work, what has meant most to you?

Almy: The people whom I trained and who have succeeded in the ways in which they are working, and the sense that in encouraging somebody to do something that other people are prepared to let fall will have had in the long run some effect on the quality of medical care.

Mullan: When you say, "encouraging people to take up something others have let fall," you're talking in terms of the doctor-patient relationship, and in terms of primary care?

Almy: Yes. When former residents like Hal Sox and John Wasson credit me with helping them focus their efforts on primary care and the doctor-patient relationship, I feel really fulfilled.

Mullan: A quick word about the future, as you see where medicine is headed. Optimistic, pessimistic?

Almy: It depends on what happens to managed care. As you'll see from this thing in the *New England Journal*, the sounding board, I've anticipated by ten years the real push for revision of the relative value scales, which is kind of stalled in mid-passage. They've made some concessions to it, to improve the lot of the primary care doctor, which I was pleading for in that *New England Journal* thing. But they obviously haven't gone far enough. Of

course, the primary care doctor is better paid now, because there's a demand for him in this economy-oriented pattern, which too many people are saying, "His fees are lower. Therefore, we'll use him more. We'll give him more authority." But this is not the way to encourage the values that the patient ought to receive from this. I worry exceedingly that the exploitation of the primary care physician as a gatekeeper by the managed care companies, the insurance companies, and so forth, could sour the whole business and set us back in public esteem, rather than improve it, which we can do if we get them somehow to value the non-concrete elements in the service that a patient receives from a physician.

Mullan: To pick up on the family side of things, you were married in--

Almy: In '43, to a lady who was then a resident in medicine at the New York Hospital. In the years that followed she raised three daughters while working part-time in the field of internal medicine., In 1963-'64, when she decided that they were now old enough not to need her as much, and she took another residency in psychiatry, and finished it just in time to come up here with me in 1968, and become one of the early members of the Department of Psychiatry at Dartmouth, from which she retired in 1980 as associate professor. She's a really remarkable woman.

Mullan: What is her name?

Almy: Katharine Swift. Oddly enough, her ancestors and mine both developed mills on the Blackstone River at different locations, one of them in southern Massachusetts--that was hers--and the other one in Pawtucket, Rhode Island, which was founded by a firm named Almy Brown & Slater, and was first textile mill in the United States. So, I feel a certain destiny at work.

Mullan: What are your three girls doing?

Almy: They have wall-to-wall doctorates. The oldest is an anthropologist, who has just taken a sabbatical from a career in the Third World, where she's been involved in international agricultural development. The second is an attorney for the Justice Department in Washington, D.C., in environmental matters. The third is the director of a section of the National Institute of Child Health and Human Development, in Rockville, Maryland. She's a demographer, and has to do with family planning and prevention of social and biological problems affecting teenagers.

Mullan: Wonderful. This has been a terrific interview, and why don't we end it now, with many thanks from me.

Almy: Well, if there's anything I can do to fill in blanks, I certainly would be pleased to be at your disposal.

[End of Interview]

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