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Interviewee: Robert Curry

Interviewer: David Brooks

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David Brooks: So it's May 26, 2006, and I'm David Brooks. I'm the interviewer for the University of Montana's Oral History Project and this morning I am talking with Dr. Robert Curry and Dr. Curry, I was hoping you could start with a brief personal and educational background and what brought you to the University of Montana.

Robert Curry: Certainly. Born and raised in Bloomington, Indiana. Educated at Indiana University. Medical degree from Indiana University. Moved to Anchor Hospital in St. Paul, Minnesota, for my internship. At that point, wanted to go west and my wife and I continued with our medical practice here in Missoula in 1959. We were with the Western Montana Clinic for one year. During that time, I worked at the University of Montana's Student Health Service on a weekly basis, spending two or three hours taking care of students.

After—[clears throat] excuse me—six years of interim visits to the University, I was hired as the director. I actually applied for the—to be a full-time director for the University of Montana Student Health Service. That was in 1965. And from that point until approximately 2002, I've been there in some capacity. Actually I retired in '95, but continued to work part-time for seven or eight years.

DB: Through 2002. So, you were in med—in private practice in Missoula for a relatively short time. What made you want to move out of private practicing to the University?

RC: Very good question. I was six years in private practice and moved in with two other general practitioners—[as] they were called at that time—family practice now. Delivered babies, had all the typical family practice, pediatrics, minor surgery, everything. Very busy. Too busy. Decided that since I was on a committee from the Western Montana Medical Society to find a full-time position at the—for the University. After interviewing doctors for two years and finding no one really interested, I applied for the job and I was duly awarded that position and have enjoyed it ever since. I knew that I would enjoy taking care of young people and especially the athletes because I had an interest in sports medicine. Being an athlete myself, I really wanted to get involved with young people and take care of their soft-tissue injuries and etcetera, etcetera.

DB: And what was the sports medicine program, as well as the Health Center like, when you first came here? And reiterate a little bit of the history of it as you know it.

RC: Well, the sports medicine program was Naseby Rhinehart. I don't know whether you know the name. He was a fantastic black athlete at the University of Montana in the late '30s. Coming from Milwaukee, Wisconsin. Very interesting story and I won't go into that, but Naseby Rhinehart was a self-trained trainer. Athletic trainer, and he acquired his education by

on-the-job training, as well as going to every conference he could find and doing courses and eventually, during the '40s and '50s, actually began to put together an athletic training curriculum and therefore, he was pretty much the sports medicine person.

Physicians who helped him were local physicians. Whoever happened to be willing to give some service to him and the athletes and, of course, when I came on board in '65, I took that position over and was the team physician for all sports for essentially the remainder of the time that I was here. Naturally, I had help from my staff as I hired other physicians on during the '60s and '70s and '80s. So, it's been a gradual increase in activity in sports medicine. I taught a sports medicine course from the '70s on until it was taken over by one of my predecessors [successors] and enjoyed it very much.

What I was primarily doing was teaching the coaches who were getting advanced degrees, some nursing students who began to have classes here, and physical therapy students who were in my class and it was a good class. We took students to, right to the operating rooms, let them see surgery on knees, ankles, elbows, hands, whatever, and it was a very enlightening experience for them to actually witness the surgical procedures that we talked about in class.

DB: And there were operating rooms on campus?

RC: No, no. These were the local hospitals.

DB: Okay.

RC: St. Patrick Hospital. Community Hospital.

DB: So, you were working in conjunction with local hospitals. They allowed the staff from the University, as well as students to attend those sort of things.

RC: They used to. That, unfortunately, because of liability concerns, no longer exists.

DB: When did it go out of existence?

RC: Oh, approximately, I expect 1990. Something. Maybe earlier than that—'85. As you know, the legalities, problems of medicine, and all the privacy things now absolutely eliminate that potential, but it was a great thing at the time. Students really appreciated it. I would take one, two, three students with me. We would actually gown and mask, cap, and go over into the operating room to view what was going on and that part is no longer available to our students, but at the time it was well-received and I think students learned a lot from it.

DB: And at the time, what were the medical facilities on campus? I mean now you go to the Health Center, the Curry Health Center, and there's a pharmacy. There's a dental office. You

have full outpatient care anyway. You know, you can go in and have a physical or be looked at if you're sick and that sort of thing. There's certainly no surgery, but there's quite a facility there.

RC: Yes.

DB: So, how does that compare?

RC: Well, in—there was a building built in 1955, a land grant, and that facility actually housed a pharmacy. There was a state mental health facility in the basement of that building, which was not part of the University as such. It was a state-operated mental health clinic. Upstairs the Student Health Service existed with inpatient facilities or limited care. Obviously we didn't do any ICU or any type of surgical care, however, we could take of our post-op cases, appendectomies, etc. Orthopedic procedures that were completed and needed a day or two more of rest, we could admit them into our facility and we had 24-hour nursing and we had an emergency room where we could do minor things such as suture up injuries, lacerations, etc. Take care of sprained ankles and banged up knees, shoulders, whatever.

Therefore, we felt that as a limited facility we could take care of most of the things. Probably 99 percent or 98 percent of student problems that acutely occurred, day or night. And if we couldn't, we knew exactly what to do with them, where to send them, and pave the way. So, we were their number one medical resource, we felt, and our educational possibilities were just enormous. This is a group of people who had never been on their own. They leave mom and dad and they come to the University and they're wide-eyed and bushy-tailed, but they don't know a thing about how to take care of their medical problems. So, we tried to fill that gap and there's many ways that we did that.

DB: Mm-hm. So talk a little bit about what their medical concerns or needs were at the time. Both, I suppose, acute things you saw, as well as what were the daily concerns that students had and would come to the medical center for.

RC: Well, everything you could possibly conceive. The important issue was that students realized that we were right on campus. We were readily available. They could come in, as we say, 24 hours, seven days a week. Most of the problems were relatively minor, but we would see anywhere from a 150 to 250 students a day. That's average. As soon as I was hired on as full-time director, I immediately hired another full-time person and within a couple of years we had four full-time physicians—had to have, because of the number of students that we saw. We also oriented the freshman to the fact that they could come to this student health service for any medical or dental need and the dental service came into existence in the late '70s, which—we were one of the first facilities in the United States to offer dental care and we did that because the students required emergency dental care fairly frequently and we were having difficulty placing them in the local dentists' offices. So, we had help from some of our local dentists to provide a place so we started with operatives and so forth for the dental service and

hired a full-time dentist within a couple of years. Two full-time dentists and so our dental services were very well received and very well used.

DB: So, I was reading the Curry Health Center's mission statement this morning and just to start out the beginning of it, it says: "Curry Health Center provides affordable, accessible, high-quality student-centered health services" and you know, I've interviewed a few other people who say a professor in Sociology, who at the time, early '60s through the early '70s talks about having to go to the dean of his school to get funding just for a calculator and adding machine and here you are building a dental clinic, having 24-hour care. Where was the funding for that all coming from? And I guess in answering that, talk a little bit more about your staff size and composition.

RC: Sure. Well, that's the beauty of this system. We operated on a budget that was entirely generated from student funds. The student paid the fee. This did not come out of the University general fund. This was a specific health fee and on their registration form and their fee form, there was a specific item: health fee. Every student paid, when I came here, \$10 a quarter. Now that's fairly inexpensive health care. We also had an agreement with Blue Cross of Montana and that fee was even less. Something like \$3 a quarter and that fee took care of things that we couldn't handle, like an appendectomy. The surgery was handled downtown, etc.

Well, as you know, in the late '50s and '60s, the house call was even done back then, \$10; an office call 3. Now you can't conceive of that because your age is—you're a little young, but that's when I started in private practice in Missoula. Those were the kinds of fees and half the time, people I'd see in house calls couldn't afford it so I would write them off; didn't worry about it.

So things have changed a great deal. We obviously had needs like the dental clinic, building more facilities. We would go to the student. We would work through ASUM and the students in general, and survey and ask them, would they be willing to pay \$2 more? So, the fee would go to \$12 a quarter. And then a couple of years, we'd need something more, it would go to 15 a quarter and when I left in '95, I think our fee was up to approximately, \$35 or \$40 a semester when we changed to semesters. This is still very, very inexpensive. It's a whole lot more now. I don't even want to—in fact, I don't know what the student health fee is right now, but it's considerably more than that because of inflation, etc. But at any rate, we had a very supportive student body. We were never turned down from any requests. They always came through for us and in about a 95 percent total. I mean they just said, do it, because we appreciate what you're doing.

You asked about the staff? We had 24-hour nursing care. Excellent nursing staff. Well-trained, dedicated people that loved students. Physician staff, as I mentioned, went from one, myself, in '65 to two in '66 to three in '68, four in '70, or something like that. So, we rapidly increased our staff. I hired on excellent people. I would not hire on people who were ready to retire and

didn't want to work. I hired on people who really wanted to get in on student health and I made sure of it.

Therefore, my administrative activities were very minimal. I still saw as many patients as my team, colleagues, my physicians would see. And I felt that by doing that I would know exactly what the students' feelings were, I'd know what their needs were. I'm in the mix, and later as committees became more important to the University, I was involved with too many committees. Many times I would send a surrogate. I didn't feel that my time was well-spent sitting in a room for two hours discussing some other problem. I felt I could do a lot more if I was there taking care of students. So, that kind of gives you an idea of the type of leadership that I prefer. I like to see somebody who can lead by example, go out and do the work. If I'm an educator, I'm going to educate. I don't want to be in a committee meeting.

DB: And how much education continued in the Health Center? You mentioned when you first got here, being able to take students to an operating room, even when that went by the wayside, which you said wasn't until possibly the '90s. How much educating did you do in the Health Center?

RC: It was one of our primary focuses was to see youngsters who had never been on their own. Allow them to see what good medical care was all about and many times we would try to tell them, look when you get out of here, make sure you find a good family practitioner or care person who has a conscience—who really cares for you and who is willing to listen, willing to listen to you. Because that's what makes a good physician is someone who is a caring person, who has a conscience, who really wants to do the right thing and will listen to your complaints. And as you well know, one of the biggest complaints that I hear about physicians is they don't take the time to listen. So, if they don't listen, they don't get the full story and many times that leads them down the wrong trail.

DB: Mm-hm. So, how about some of the educational campaigns you possibly did through the Health Center? I mean, now you see in the college center anti-drinking and driving or binge-drinking campaigns, safe-sex campaigns, things of that nature. Talk a little bit about the different things that you did to make the student body aware of general health issues.

RC: We were into all of that. I had different staff members doing cardiovascular kinds of things. I started a fitness activity with Brian Sharkey and John Dayries in the HPE [Health and Physical Education] department and we started jogging. We had times that we would jog around the old Dornblaser Field, which was where this building is right now and, uh, that got good response. We had people who began to jog and this was back in the '60s of course.

The other kinds of things, as you mentioned, the sexuality issues, I was constantly going to dorms and fraternities and sororities talking about sexuality problems. Now, AIDS was not—we weren't aware of AIDS back then. AIDS came into view at about '85. So there were 20 years that I talked about venereal diseases and, you might call it, safe sex. What we talked about [were]

the causes, the ways to prevent [it] and a little bit about morals, actually, and it was well received, had good audiences, and it was wide open. We let the students, you know, I was primarily the one who was doing all this because I felt it was very, very important. And we talked about drugs and we talked about anything they really wanted to talk about, but sex is always interesting and people will come hear about sex no matter what. It's the most important item, I guess, on young people's minds other than getting an education—how I hope.

DB: So, do you suspect, and you know, I'm just hypothesizing here, that you came in the middle of the '60s—which of course the lay interpretation of that is free love and drugs and counter culture—was that something that you think was probably new, those interests, those willingness to talk about it, the staff from the medical center going out and approaching those issues? Was that new to the '60s and early '70s?

RC: Absolutely. Absolutely. This is when birth control came. The birth control pill came in the '60s and this was a hot issue every place, but not here. We did not feel that this is an area that we should be doing any kind of judging as far as who should be on birth control, who should not be on birth control. What we needed to do was treat each case individually and educate as we go and we found that this was also the time when abortion was illegal. This was before *Roe v. Wade* and there were illegal abortionists in the state of Montana. I can even tell you the communities, but I won't. Therefore, students were, if they became pregnant, they would go to these illegal places with their cash in hand and an appointment and have an illegal abortion and not a very sterile procedure and many times we would have very sick kids coming back to campus and we would have to hospitalize [them] with sepsis, with really serious, serious infection from poorly done medical procedures.

So, we tried to use common sense. We tried to preach the fact that, you know, if you were going to be sexually active, you should be safe and you should use birth control and obviously venereal disease is brought into that, but back at that time AIDS wasn't a problem. We could treat gonorrhea and syphilis and we didn't have very much of it, but it was out there and students were infected on occasion and we would take care of that.

But [providing] birth control was not an issue for us as it was other health services. Our sister institutions sometimes would not deal with the problem. They would say, "Well, you'll have to go downtown." Well, we felt that this was *our* job. This is the job of the student health service to get on board with students and discuss the problem and if we felt individually that they needed birth control, we would write the prescription and follow them. Obviously with a good pelvic examination, a pap smear, and breast exam. The whole nine yards and that to me made good sense because we could follow them, we could educate as they went along. They're maturing. They're finding their way and it made good sense. We had absolutely no policy. Everybody said, "What is your policy in regards to birth control?" I said, "Excuse me? That's an individual issue. We have no policy regarding birth control." Therefore we had no problem. None whatever. We did not have *any* issues on our campus in regards to birth control.

DB: And so before you said, you know, you had something like 95 percent support when you went for extra funds for the health center or just the health center in general was widely supported, but I suspect that if there was any opposition, it possibly surrounded these issues.

RC: Well...

DB: Is that true?

RC: You know, I couldn't tell you exactly why because there were so few opposed to what we were doing that the issues were kind of non-existent. I mean some people just vote no because they didn't want to spend the extra couple of bucks and didn't have any particular reason, but just said that, agh, I don't use the health service. You know, there are those out there that would do that and I had no problem with that at all, but because the great majority use the Health Service, we would do the research on our records and find that approximately 75 percent of the students would use the Health Service at least once a year and by the time they get out of school, almost 100 percent have used the Health Service.

I don't know how that percentage would work out today, but we felt that we were visible and that we were doing something and as you say, we were trying to educate. We did this also with the faculty. We wanted our faculty to *know* that we were there to help them with problem students. So, I met with the department heads of every school in the University. I would ask them if I could come to their faculty meetings so that I could talk to them. Not only the deans of the faculty, but also the faculty themselves, and there's quite a few schools and there's quite a few deans, as you know. And we came to them and expressed the fact that if you had problem students, if there's somebody depressed, somebody not attending class, and you have a suspicion there's something going on with these people, please call us. Or bring the student over. Give us a call, let me know what's going on and we'll make sure that the student gets some attention. And the faculty really appreciated this and many would do just exactly that and they would have a problem student, a problem situation, they would actually call themselves. The faculty themselves would call the Health Service and say, "Hey, I've got a problem here. Could we come over and see Dr. Curry or somebody?" And of course, I had my staff clued into this and they would say, "Yes, right away." You could be seen and there was always a situation where we had physicians on call so that that could happen and did happen on many occasions.

DB: So that reminds me. When you said you first got here, there was a state mental health facility in the basement, or in the downstairs. How much did you deal with mental health and in what ways? What was your capacity to do so?

RC: Well, as time passed, that mental health unit was transferred out to Fort Missoula. It's still under state [control], not under the University. So, we decided since we didn't have that facility close at hand for referral, that we actually hired mental health people to come into our facility and set them up with offices. And so we had a psychiatrist, a psychologist, a psychiatric nurse, and so we had a little psychiatric unit ourselves. And yes, indeed, it was big part of the student

health service because as you know, mental health problems exist probably more today than they did back then, but they are always there and it's just a matter of identifying them and getting them to seek help because it's a pride thing. You don't want to go to see a mental health worker if you don't have to. And it's becoming more and more accepted and people don't even think much about it now. Depression is so common and other mental health problems are now accepted. Don't worry about it. We can treat and you can get better.

DB: So, I'm going to ask you a question that's probably a little broader than just the University, but that's something that you hear a lot of is that depression is very common now. We're learning, you know, Attention Deficit Disorder is one of the more recent phenomena, really, in mental health. Especially in young people and [where] education is concerned. Are these things that were just missed before or are—have these developed and blossomed, which is probably not the right verb, but...?

RC: That is...

DB: Which way is it?

RC: You know, I wish I could answer that intelligently, but I can't because I, to be perfectly honest, when I was involved with the '60s, '70s, we did not have attention disorder problems. Period. I mean they just—we weren't aware of such. We were certainly aware of depression. We were aware of schizophrenia. We were aware of lots of disorders, bipolars, etc., etc. But as far as attention deficit, all we would know probably was that, hey, this student doesn't take tests well or this student isn't seeming to—seems to be a bright student, but not learning. What's going on here?

We did not recognize those problems. I don't know how frequently they existed. I don't think very frequently. I really don't think the problem was huge, but it was there. No doubt about the fact that it was there. As time progresses, I don't know what happens, but things change. Depression may or may not be more prevalent. I suspect that it is. There are a lot more problems in the world. There are obviously more ADHD, all that Attention Deficit business because people were looking for it and it's being found and the problem is sometimes you overreact, sometimes you over-treat and there's lots—you read lots of stuff in the newspapers. What's going on today, the medication and the treatments may be worse than the disease. So, things change. That pendulum swings.

DB: So, speaking of that sort of change, let's talk about the arc of change in a few things and the first is, um, you know, can you make an assessment of either mental or physical health in whether students on this campus that you saw, whether those things improved, declined, you know, and I don't know what factors to even measure? You talked about cardiovascular fitness or weight is certainly something that's on everybody's radar these days.

RC: Sure.

DB: So, a few of those, you know, major, major characteristics that you think of when you think of general health...

RC: Do you think...

DB: Can you track an increase or a decline in our health?

RC: Well, at, at—here's my answer. We're obviously declining. We're declining morally, physically, in all those areas that I was so interested in stopping. I have this to say, and I hope it's accurate. When students left this university they knew about fitness. They knew about weight. They knew about blood pressure and cardiovascular things. That was *on* our agenda all the time and we constantly worked against smoking. I mean, we had programs. We had all kinds of things and therefore, I think, I hope, that we had an influence on those people that we saw during that period of time. Obviously, it hasn't helped. Nationally, or internationally, too, possibly, but this would be the hope. That we would reinstitute our physical education programs. Reinstitute exercise and activity and limit TV time and limit some of these things. And the only ones who can do it are the parents. So, we've got to keep after it and educate parents.

DB: How about the change in essentially pharmaceutical care and university students, you know? That—my wife and I went away to Japan for two years and the thing we noticed when we came back is turning on the television and suddenly you see drug advertisements and that seemed to happen within the two years we were gone or we picked up on it. How did that come about on campus? At what rate? And you know, you had a pharmacy there from the beginning.

RC: Sure. Sure, sure.

DB: But changes in prescription drugs, in your abilities to prescribe. What was being prescribed?

RC: Well, we—you know, back in those times, '60s, '70s, '80s, these students appreciated the prescription we gave them because they had a specific purpose and generally a dosage regimen of a certain time span and that was it. There were no advertisements because pharmacies—it was unethical to advertise. There were no physician advertisements, I know, and everything has changed in the last 15 or 20 years in regards to advertising, drugs, physicians, services of that type because it was kind of an ethical issue.

Now it doesn't seem to be an issue. It's just that's what they do. And, uh, it's not real pleasant, for me, to see that because I was born and raised in an era where that did not happen. But as far as the health service, I, we have to take it in stride. We have to do as we know to do and try to do the best we can, ethically, and we take care of all our records confidentially. We take care of all the information, the signature—you have to have this to track anything. Everything is

different now. Much more closely guarded. Probably overkill, again. We over-react and the pendulum goes too far one way, but the Student Health Service stays abreast on all of these things. We're right on top of things. Nationally, when we go to student health conferences that include all universities across the nation, we're on top. We've never been anything but right on top, where we need to be and that's very important.

DB: So, you clearly kept abreast while you were the director of other university health centers.

RC: Oh, yes. Oh, yes. Absolutely.

DB: And when you say you were on top, just give me some comparisons. How does the university's health center or how has it fared compared to other university health centers?

RC: Well, this is totally a selfish view, but we've fared very well. As I say, we were one of the first services that had a dental unit. We are one of the very few who continue to offer inpatient services for students who are ill and need a couple of days of R & R in our facility. Most other student health services have closed up all of their inpatient facilities. They just run a clinic from 5...or from 8 to 5, excuse me, and that's it. They don't offer emergency services. They don't offer weekend care. It's really changed a lot. We have not. We have maintained a feeling that we need to be the student's primary medical facility and take care of their needs from A to Z, if we possibly can, and if we can't, we know where to get that care. So, I think that sets us apart and as far as I'm concerned we're on top of the field. We have a good physician-to-student ratio. You know, we have one physician for approximately every 3,000 students, which—that's a lot of students to be taken care of for one physician. That's just a broad view. General practice, one per 1,000 patients is average. One physician per 1,000.

DB: So, with the growth in the University and those ratios, you know, my wife is a nurse and has been for a while, and the one thing she noticed has changed, even in her time in the medical field, is actual time with patients, as opposed to time in front of paperwork. And earlier you mentioned, and I think proudly so, that you didn't do much administration and certainly there's been some administrative growth in the health center here. How have doctor-to-patient, or nurse-to-patient times changed with those sorts of loads and is that something that you think the University does a better job at keeping in balance, than say medical facilities in the community, or in the nation as a whole?

RC: Well, I think we're very aware of the fact that you need to listen to what the patient's telling you. The trend toward students being older, you know, the average age, when I started, the student average age was probably 20, 21, 22. Now, it's probably closer to 30 and we're talking average age. We're talking freshman and grad students, and the whole mix. So, the problems obviously change a bit as you involve people of middle age and their problems are different than teenagers.

So, you have to change your method of seeing these people and give them a little bit more time because they have more complicated problems and issues. A simple upper

respiratory infection generally is taken care of by a nurse practitioner. Doesn't need to see a physician and that's perfectly logical. When you get into more involved medical problems, then the physician needs to be involved and it may take longer and it may need and require more time. Plus, our patients are more sophisticated. They're watching those TV ads about medications and the doctors, so they're inquiring more and more and they're requiring time. So—

DB: But no house calls anymore?

RC: No. That's way, way beyond that. Emergency rooms came in at that point.

DB: So, we've been talking about what I'd call, sort of chronic or habitual issues in health care: smoking, obesity, cardiovascular health, things of that nature. How about acute things you saw in your time here? Were there any special needs that were timely by way of the Vietnam War? The Gulf War even, the first Gulf War? You were here at the tail end of that.

RC: Yes.

DB: Any sort of epidemics? This—we're in the age of terrorism alert. We're aware of places like the University campus being very vulnerable because of the number of people in shared space.

RC: Well, as you well know, President Bob Pantzer was the UM president during that Vietnam period of time and we had a fair number of so-called riotous conditions, but he handled it extremely well. We were minimally involved, but as students would become anxious or acutely aware of that type of thing, we would see them acutely and handle them, I think, pretty appropriately. Because acute things can be handled acutely and calmed down and mature. You get along.

As far as really acute things that made a difference in our outfit—influenza, infectious mono—those were the kinds of things that would become epidemic and we can remember having absolutely full, a full health service full of inpatients, 30, 40. We could take care of that many and it wasn't a matter of a long-term care, but a day or two or three to get their fever down, to get them feeling better where they can continue their own care back in the dorm or wherever they were staying. So, we had some real major epidemics that we handled, I think, very appropriately and got by very well. Had very few bad results from that.

Mono, when I first started practicing, it was a disease where you could only do bed rest. Well, within a few years, medication was available that would turn it around so that you could—you didn't need to send students home to recuperate because they couldn't get to class because they were so tired and just not able to function. With new medication, a day or two of bed rest and they were ready to go and it made all the difference in the world. So, we saw fewer and fewer inpatient days because if they come in at the right times, we can pretty much avoid the inpatient need. So, I think acutely we just, wherever the ball bounced, that's where we would

go and try to extend the tide and make sure that, you know, flu shots now and everything. That's big time.

DB: Were there any particular acute health issues that were perhaps not so much beyond campus? In the community in general? I mean, every year you have cycles of flu, perhaps even mono. Any particular outbreaks on campus you remember vividly?

RC: [pauses] No. Not—perfectly honestly, what I mentioned to you with the flu and that type of thing—now, we'd occasionally have some chicken pox. Occasionally, we'd have measles back before the immunizations, etc., but nothing major. Nothing that was, you know, blown out of shape. Food poisonings? Minimal because we had great food facilities on campus. Well-monitored. We had a great sanitarian, Ken Reed, back in those years and he did a marvelous job making sure that everything was sanitized, if you will. So, we, we had a good team. It worked well.

DB: So, you've mentioned President Pantzer and Mr. Reed. Name some other folks that came through during your time that were significant or memorable.

RC: Well, we went through a lot of presidents. From Bob Johns through President Dennison, of course, and a lot of acting presidents in between. But, uh—

DB: How about on your staff?

RC: On my staff? Great physicians, Dr. Bob Ewick, Dr. Paul Wagner, who just recently passed away. Dr. Jack Brockner. Rich Paulson. These are guys that spent years and years and years with me and the new people that are on staff now, Dr. Paulson is a senior member, of course he's been there. I hired him many, many years ago and the rest of the staff are relatively new and good young people, interested in students' health and that's what we need.

DB: So, of course, the Student Health Center we've been talking about is now the Curry Health Center. So, you obviously have left something to the University that people find significant. I'm going to ask you to sort of brag on yourself here and tell me why it is it's named for you? What did you leave here?

RC: I have no idea. I had a wonderful staff who worked hard. They didn't need any real direction other than pointing out the fact that we work for the students. Period. We don't work for administration. We don't work for publicity. We work for the student and that came through loud and clear with what our staff would do. So, it was a very humbling experience to add Dr. [Nancy] Fitch who pre—was my predecessor [successor]—suggest that they name the building after me. I thought, 'My goodness. I'm not dead yet. I haven't contributed a million dollars,' of which I never could earn because I worked for the state. At any rate, it was very humbling. Believe me, it was quite nice.

DB: I'm sure you're being modest about your influence. Thirty years is a good amount of time and I'm sure that the building is named for you for just causes.

RC: Well, let's say this, the best leadership is by example. If you get out and do your work, work hard, and be as honest as you can, good things usually happen.

DB: Well, I think we'll end on that note.

RC: Good.

DB: I appreciate your time. Unless there are any stories that you would like to add to the record here that I haven't touched on.

RC: I appreciate it. My pleasure.

DB: Thank you very much.

RC: You bet.

[End of Interview]