1997

James H. Black Oral History

Philadelphia College of Osteopathic Medicine

INTERVIEW WITH REAR ADMIRAL JAMES H. BLACK, D.O.
(CLASS OF 1962)
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
January 24, 1997

PERLOFF: Admiral Black, please state your full name, date of birth and place where you were raised.

BLACK: James Howard Black, [redacted]

CBP: Where do you currently reside?

JB: [redacted]

CBP: What made you want to pursue a career in osteopathy?

JB: Well, I went to an osteopathic physician from the time I was very young. And if you were to interview my mother, she would tell you that she doesn't believe that I would have survived childhood if it hadn't been for the good care of an osteopathic physician. I was very young -- my recollection prior to school, so four years old, I suppose. We went to Dr. George Stineman in Harrisburg, and he was a general practitioner, and then went off and did a residency in pediatrics, and I can recall him doing that. I'm not sure that he left town for a long period of time. I don't recall now whether he did it as a preceptor/preceptee-type situation. I think that may have been the case in those days, but since I was so young, I didn't understand, and don't really recall. I had my tonsils out in his office.

CBP: Was he a PCO grad.?

JB: He was a PCO grad. And then when he relegated his practice to strictly pediatrics, my parents went to a different physician, and at that time Dr. William Martz opened his office in Steelton, Pennsylvania. I think my mother was probably his second or third patient, and she went to him until he had to retire from practice due to ill health, and died a number of years ago now. But it was Dr. Martz and his wife who brought me down to Philadelphia to visit the College, and then later encouraged me to apply here.

CBP: Was Dr. Marks also an alumnus?

JB: He was an alumnus of Philadelphia, as well.

CBP: What college education did you complete prior to matriculating at PCOM?

JB: I went to Gettysburg College and got a Bachelor's Degree there.

CBP: What was your major in college?

JB: Biology, and a minor in chemistry and psychology.

CBP: Why did you select PCOM over any other osteopathic college, or did you even apply to another college?

JB: This is the only school that I applied to. The only medical school.

CBP: What were the highlights of your educational experience at PCOM in the late 1950s and early

1960s? Courses, for example, or professors who impressed you significantly?

JB: Well, I guess the first one that comes to mind -- I just left the lunch with the military scholarship students, and was talking with them a little bit about those days. Dr. Angus Cathie, I think, is the one that always comes to mind immediately because he was not only one of the best anatomy professors, I think, but he was also colorful in the way he taught. He was extremely talented as an artist, and could stand in front of the blackboard and draw anatomy with colored chalks with both hands pretty much at the same time, and talk the whole time he was doing that. We didn't have the technology that the students have today with the computers and the power point, and all the advanced software that they're able to create and use in teaching. But we had Dr. Cathie, who could do all of that by himself, for the most part. It was incredible. And at the same time, you feared him because he was very strict. His personality was one where he was very firm and strict, but he was also very soft-hearted, as well, and would do anything, I think, for a student that showed the least bit inclination for wanting to learn. He would help in any way that he

could. If you were sick -- he was also a master at manipulation, and would treat you. He was just quite a person, and I think he stands out as one of many, but probably the first person that comes to mind when you think of the faculty during those days. There were some other very interesting folks, too. We had Dr. Wilbur Lutz, who taught physical diagnosis, and he and his wife always attended all of the social functions, particularly at the fraternity house.

CBP: Which fraternity house was this?

JB: Phi Sigma Gamma. One of the things unusual about him was that he collected limericks, and there were times I can recall where we would have a physical diagnosis class, and he would start out and people would give him limericks that they had that he didn't have in his collection at the time, and I was discussing this with my wife on our drive up here yesterday, and said that there would be no way that you could get away with that today. [laughs] But it's an interesting memory. And then there was Dr. Py, who would come in to teach us, and he always looked like he just stepped out of some fashionable clothing store, and he always wore a flower in his lapel.

CBP: This was bacteriology?

JB: Yes. Dr. Cressman taught us dermatology and really taught us the most that there was about writing prescriptions and compounding prescriptions. In those days, that's the way it was all done. Today if you ask a pharmacist to compound a prescription, they just kind of look at you with a blank stare because it's just not done, for the most part, anymore. He was a great teacher. Dr. Kohn, Dr. Evans were all kind of giants in their field. Dr. Jake Leuzinger in pulmonary medicine and bronchoscopies.

CBP: Were there any particular courses that stick out in your mind? Course material?

JB: Well, one that sticks out in my mind that I had probably the most difficulty with was our biochemistry course, and it was extremely tough for me. We had a classmate, Dr. King -- Bill King -- who is also on the Board of Trustees of the college here now -- who had a long-standing background in chemistry prior to coming to PCO. And if it weren't for him tutoring us -- some of us who had difficulties -- I probably wouldn't be here. I wouldn't have made it through. It was tough. He was both a classmate, but a good teacher, as well.

CBP: You were among the last generation of PCO graduates to receive your clinical training at the 48th Street Hospital. Please share your collections of the facility and the West Philadelphia neighborhood during a time in which plans were being made for the Hospital's move to City Avenue.

JB: Well, of course, when I got to school at 48th Street, there was a big sign across the street that said, "Future site of Philadelphia College of Osteopathy," and that was sitting there in a parking lot. It was there for a number of years, and then they purchased the City Line Avenue grounds during that time, which we were all very excited about. But I think it was like ten years after that that they finally got to the point where they built something out here.

CBP: Do you know why they shifted from expanding in West Philadelphia to moving to City Avenue?

JB: I really don't know the answer to that. Dr. Barth was the President at that time, and I'm sure that they probably had some good deal in purchasing this property. So after they purchased it, they sold a corner off here to the television station. I think that helped with the mortgage. I don't know. If I had to guess -- and as I said, I don't know for a

fact -- it was probably because the city was changing at that time, and this was looked upon as probably a better site for a college with St. Joseph's down the street, and it's a better neighborhood -- upscale at that time. The facilities at 48th Street, as far as the clinical part goes --

CBP: Or the academic part, as well. The overall building complex that you had there.

JB: Well, it was fairly old, but it was maintained, as I recall, pretty well. And for the standards in those days, it was not all that bad. Our classrooms were not large, but then the classes were not large. My class had less than a hundred people. Each class had a classroom, and in those days, we had academic training -- classroom training -- for the first three years, for the most part. Then, in our junior year, we had a little bit of clinical experience, but not a whole lot. And we were told then that we were not allowed to go to any other hospitals, and if we were caught doing so, we would have been thrown out of school. We had a lot of folks that did it, but it was a clandestine-type experience, and I remember going at least one time to Bristol, I think. You went very far away, hoping that nobody

would know who you were. Now, I'm sure that the administration probably did know, but they still had the regulation and didn't enforce it that much.

CBP: Why were they so strict about that?

JB: I have no idea. That's just the way it was. I don't know why.

CBP: What kind of exposure were some of the other students getting by going to these other hospitals, or you, when you went to Bristol?

JB: Well, you got clinical exposure, where you were dealing with real patients and seeing physicians practicing in a hospital setting, whereas students -- it was all academic.

CBP: But how were you getting into those clinics with the doctors there? What was your entre to get in the door?

JB: Somebody knew one of the doctors and he would just go with them. That's the way it was done. Then the experience that we had at the hospital -- we had a full service community-type hospital at 48th Street, and then we had the ambulatory -- what we now call ambulatory care -- it was the out-patient clinic down in the basement, where everybody had a booth and a little cubicle where you saw your patients.

CBP: We were all referred to as a booth doctor, in those

days. We had 20th Street, as well, and we had both outpatient and inpatient care. That was in a little rougher section of town -- 20th Street. I was very naive and didn't realize in my senior year -- I had night duty over there, and we had a building across from the hospital. It was still on the grounds, right across the parking lot, which was kind of a dormitory-style. It had an open bay with beds, and then there were a few private rooms where the residents stayed. But as a student, they just had a bed out there in the dormitory area. I was the only one there, and on a couple nights, just slept there by myself. A few nights later, one of the more senior folks who had been around for a while came in and was going around locking all the doors, and I didn't realize that you should have locked the doors -- that you really weren't all that safe. [laughs] And you did hear gunshots in the neighborhood at night. But it was an interesting place. That was a much older facility. I can remember the operating room there. There was no air conditioning, and you had the windows opened. They were screened, of course, but the windows were opened. Just totally different then, than we would operate these days.

CBP: Was 48th Street air-conditioned?

JB: I don't think. I remember getting warm in there, and we had an amphitheater. I don't think it was air-conditioned, but it was ventilated differently. I don't know how. I don't recall open windows, like I do at 20th Street. Again, that's been a few years back. But it was an interesting place.

CBP: Please describe the clinical training you received in the hospital clinics at 48th Street and North Center, commenting on things like supervision, number of hours, etc.

JB: Well, it was an hierarchical set-up. The staff physician had residents that were assigned to him or her -- but in those days, mostly, I think the ones I recall were males -- and then they would have interns, and then the students were assigned to the service and worked under the interns. There were a lot of people trying to get educated, and we would make rounds with the attending physician for the inpatient care. Many of those physicians in those days -- both medical and surgical patients -- wrote for OMT to be provided to their patients maybe twice a day. So as students, we would be required to do that. I can recall on OB, that sometimes it was so sporadic and you could have that rotation and there may not be many deliveries. I recall staying there

for probably twenty-four hours or so because there were some women in labor, and you wanted to have the experience of being there for the deliveries. So you just stayed around the clock in order to do that. Dr. Eisenberg, in those days, did a lot of natural childbirth, and many of those physicians, by the way, took care of the students' families, and they never charged us anything. A lot of us had kids.

CBP: Including yourself?

JB: Including myself. Yes. We had one, actually, when we got to Philadelphia, and then had a second daughter, I guess in my junior year. It was either late junior or early senior year. Dr. Eisenberg delivered the second child. Dr. Wagner was our pediatrician before he moved out to Michigan, I think.

CBP: I've heard references to Dr. Wagner having a pediatric clinic. Was that at 48th Street, or was there a clinic that was still operating in the Spring Garden Street Building?

JB: I don't recall. When we took our own kids there, we went to his office downtown. But he had a residency program. The chief was a female, who was in Des Moines as a Dean or Assistant Dean (Pat Cottwell).

So I'm sure that if they ran an outpatient clinic there, it may have -- I don't know where it was.

CBP: It might have been before your time there.

JB: It could be. But he did inpatient pediatrics, and they had the residency program.

CBP: During the 1960s, PCOM students obtained supplementary clinical experience in the Harbor Light Clinic of the Salvation Army and Embreeville State Hospital.

JB: I never went to Embreeville, but I did go to the Salvation Army clinic downtown.

CBP: Where was that located downtown?

JB: It was down around Race and Vine, I think.

CBP: What do you remember about it?

JB: We went up to a second floor, and there was a big open room there, and we'd see many of the same patients, and a lot of them had skin problems, and they had ulcers which came from alcohol. A lot of them would actually drink plain wood alcohol. Anything they could get their hands on. But it was a good experience. We saw all kinds of patients there. We did that, I think, in my senior year.

CBP: Was this on a volunteer basis, above and beyond your clinical responsibilities?

JB: Yes, it was voluntary. I'm trying to remember who

supervised us. There were some faculty members who, I believe, were in private practice in the area, and volunteered their time as faculty, that would go down and supervise us. I don't remember now how we got our supplies and things -- whether the College donated those. I don't recall. But we'd go there once a week, on an evening.

CBP: Do you have any sense of when that clinic started and when it ended?

JB: No.

CBP: Now, you did not go to Embreeville?

JB: I never went to Embreeville.

CBP: Were students during your year going to Embreeville?

JB: If they did, I don't recall.

CBP: Okay.

JB: Now, I worked the whole time that I was in school, on weekends and during the summer, and I used to work Monday evenings, right here at the Philadelphia Psychiatric Hospital. I don't know what they call it now.

CBP: The Institute?

JB: Yes. As an attendant. So I had a fair amount of psychiatric exposure over there. But that was to augment our income.

CBP: And that was not in conflict with the rules about

not going to some of these other hospitals to learn?

JB: Well, I wasn't there as a student. I was there as an employee. And not as a physician, but just as a psychiatric attendant.

CBP: Did you have any other opportunities to acquire practical experience while you were a medical student? For example, any home deliveries or assisting in doctors' offices?

JB: I didn't go out into any doctors' offices. When I was at 20th Street, we always had the home delivery kit ready to go, but I never went during my rotation there. However, I did go out one time for a house call, and that patient turned out to have Guillain-Barre Syndrome. It's a neurological disease, where you get ascending paralysis, and frequently have to be put on a respirator. That was the only case I can recall ever seeing. We had read about it in the textbooks, but I had never seen one. I don't recall now who I went with, but I think it was a medicine resident.

CBP: In 1961, James M. Eaton, D.O., who was Class of 1928, died suddenly from a heart attack. He had pioneered orthopedics at PCOM. Could you please share your recollections of Dr. Eaton from the standpoint of a practitioner, an educator, and any

other ways you might have gotten to know him?

JB: He lectured to us some, but his Assistant in the Department, Herman Poppe, did more of it, as I recall, of the orthopedic lectures than he did. Dr. Eaton had quite a reputation in the school as being a very progressive-type orthopedic surgeon, and he did a lot of spinal-type surgery, which now -- and even then, I guess, maybe, in the medical institution or the allopathic institutions -- were done by the neurosurgeons and the laminectomies and things -- Dr. Eaton did a lot of that. A lot of the students -- and I never, I don't think, worked in the O.R. when he was doing a case. I think I observed, maybe, from the observation area. He was difficult to work for. And in those days, a lot of orthopedic surgeons had reputations of being kind of nasty in the operating room to work with. But as I said, I never experienced that.

CBP: While you were a medical student, Sherwood Mercer was Dean.

JB: Yes.

CBP: Could you please comment on his contributions to the College during the 1960s?

JB: Yes. My first introduction to Dean Mercer was during the interview for applying to the school, and

that was rather unusual, and Dr. Mercer had -- or may still have -- I don't know -- kind of a tick, and he would grimace. And there as an interviewee, applying for school, I was -- and I think many of the students -- were extremely nervous. Dean Mercer would look at you and he would do that [grimace], and you would smile back, and then after a while, you learned that he wasn't just smiling at you. [laughs] And then you became even more uncomfortable because up to that point, you were doing the same thing back. [laughs] But I think he was very interested in the students and the curriculum and trying to be sure that we got a good education. However, as I had mentioned previously, the administration at that time felt that you could only get education within the walls of 48th Street, for the most part, and didn't want you doing anything outside or that hadn't either been approved or planned for by the administration. And I don't know why.

CBP: Do you have any sense of when that attitude changed?

JB: I think it changed after I left.

CBP: Can you think of any person that sort of directed that change -- administration, a Dean, a President?

JB: I don't know. Anything I would say would be

strictly conjecture or a guess on my part. I'm not really sure. But it did change, thank goodness. I'm not sure exactly when. And I had a lot of classmates at the time who were very unhappy with the administration, and many would say they would never join the Alumni Association, and had no desire to ever come back to the school. And I'm sure that I probably shared some of those sentiments at the time, but they couldn't have been very strong because I joined the Alumni Association and I had always belonged, and I've come back on a routine basis. Because even though you may not have agreed with the way things were done, I suspect that if we talk to any of the students individually now, you would get the same sorts of comments. Whereas, as a student, you're never really pleased with the way the administration is probably running things. But you're unaware. You don't have the big picture. I don't know why they operated the way they did, but I think we got a good education, and they had a lot of successful people. So it couldn't have been all bad, could it? [laughs]

CBP: That's right. [laughs] While you were a medical student, D.O.s in California were merging into the State's Medical Society.

JB: Yes.

CBP: And trading in their D.O. degrees for M.D.s. Can you recall your personal impressions of this at the time and/or the sentiments of your classmates while this was happening in California?

JB: I'd have to just try to recollect how I felt about it, and I'm not sure what the sentiments of my classmates were. I know that there was a lot of to-do about it, and we had literature and many of the older faculty members that were very upset about it. I personally felt that it was definitely wrong, that we had a good profession and there was no reason for them to merge in California. I think that we've done very well with two separate professions working together, and in my position, for the last twenty-some years in the military, I've had very close and personal experience with working together with allopathic physicians as well as osteopathic physicians. You know, it can be done very nicely. And we both have contributions.

CBP: What were the highlights of your social experience at PCOM and in Philadelphia in the late 1950s and 1960s, given that you had a wife and two children by the time that you graduated. [laughs]

JB: We had no money, to begin with. Early on, our

social life pretty much consisted of going to the fraternity house on Saturday nights.

CBP: Where was the fraternity house located?

JB: It was on Spruce, the next block down from the College, across the street. In the basement, beer was free if you paid your dues, and I was elected to be Treasurer, so I actually got a small stipend for doing that and was able to attend an AOA convention in Kansas City during that period of time. It was the furthest that I had ever flown, and I think it's the furthest away from Pennsylvania that I had ever been at that point in time. But we could go there as a family, and that's what we did, because we couldn't afford to do anything else. Then twice a year, I believe it was, we had student council dances, and we usually came out here to -- I can't remember the name of the ballroom, but it was Uhrs, and there was a delicatessen next door.

CBP: Was this on City Avenue?

JB: It's just off of City Avenue.

CBP: On the Philadelphia side?

JB: You know, I'm not sure. It's not very far from here, though. I mean, if you go in that direction -- maybe a mile. Or maybe not that far. I can't remember the street numbers. But it seemed like it

was in the sixties. I'm not sure.

CBP: That's not very far.

JB: It wasn't far at all. But that's where we usually had our big student council dances. And they were always held right after exams, so we lived it up, royally. I think -- I'm not exactly proud to say it now -- but the biggest hangovers I ever had were from those student council dances! [laughs]

CBP: [laughs]

JB: But we had a good time. Then, there was always a Christmas party, and they had skits and things, and that was at 48th Street in the auditorium. And we always had a picnic in the summer.

CBP: Where were the picnics held?

JB: I don't know. Parks somewhere, in the area. And you could take your family. It was a fun time.

CBP: Was married with children the norm at that time?

JB: It wasn't unusual. Not as much the norm as it is now. And in my class, we started with one female, and she left, I think -- I believe it was the end of the first year. So we had no females in my class. And the other classes around that time didn't have that many females.

CBP: Why do you think that was?

JB: I'm not sure because in osteopathy, early on we had

a lot of females. So I'm not sure what was occurring during that timeframe. One of the other things that my wife reminded me of that we had to report to Tom Rowland any changes in our selective service status, so they could be sure to get to the Board and tell them that we were in school and full-time students, etc. Because that was still during the draft years. But I don't know why we didn't have many females. We had a fair number of students that were married and had children. In fact, we had one classmate who had -- I think they had two sets of twins and one single. They had five kids under the age of five.

CBP: This, also, could have been still the repercussions from the 1940s and the G.I.s coming home and getting to start college later, and therefore, starting medical school later, and so they're older when they came here -- and had families already.

JB: We had a number of students who were veterans and were there on veteran programs. That's true.

CBP: Where did you live while you were a student?

JB: Well, when we started to school, we lived at 50th and Osage, which was about four blocks from the school. And my wife was working nights at the College. When she became pregnant with our second

child, we couldn't afford the rent there, so we moved to Bartram Village, which was a housing project.

CBP: I know that area.

JB: The people that ran that project at the time were pretty good at trying to put students together, so that there were a number of us that lived in the same building, and close by, and we had a co-op babysitting club, so that nobody paid any money -- you just kept track of the hours and traded off. And that included students from U of Pennsylvania. Not just PCO.

CBP: How did you get over to 48th Street and Spruce from Bartram Village?

JB: We usually carpooled.

CBP: We talked a little bit about your being a member of Phi Sigma Gamma. What were some of the activities, other than the ongoing beer keg in the basement, that fraternities were active in at that time?

JB: We used to have one big party once a year, when they invited the alumni back, and I know that Dr. Vergara used to always come to that. They'd play poker, and there would be more money than I had ever seen on the tables. And then they would, of course, donate some of their winnings to the fraternity.

CBP: Early on, fraternities played a significant role in education, where an alumnus would come in and help the students with their studies or demonstrations for OMT. Was there an educational function by the time you were a fraternity member?

JB: There may have been some OMT demonstrations, but I don't recall any right now -- at least any academic-type stuff. It was pretty much just a place for socializing, and we also rented rooms, too, so there were people that lived there.

CBP: In your opinion, why do you think the number and role of fraternities have waned over the years at PCOM?

JB: I don't know, other than probably some of the reasons that you have already stated as far as -- I think the fraternities started out -- they were more geared to a single male, and we have a higher number of females. More married folks. The communities now offer a lot more things. I don't know that the requirement for the types of things that the fraternities provided then are needed now. Our culture has pretty much changed. It's very similar to what we'd find in the military with our officers clubs. At one time they were <u>the</u> center of the social life for military folks, and now we have a

difficult time just keeping them operating. Plus, there's so much competition within the communities -- one of the other things is a downplay on the use of alcohol, too. We used to have a lot of happy hours. Well, we don't have those anymore. So, I don't know. That would be my guess.

CBP: Other than Tom Rowland's basketball team, were there any organized athletics at PCO during your years as a medical student?

JB: No, I wasn't involved in any, and I don't recall.

CBP: How about intramural sports?

JB: No, I wasn't into sports personally. Right now I just don't recall. There probably were some, but I don't remember. And one of the things about Tom Rowland -- since you brought up his name -- that I remember him for was our first day in school. We had all the freshman class in the auditorium, and he spoke to us along with the Dean, and I think maybe Dr. Barth, as well. I'm not sure. But one of his statements -- and this was kind of the tone of the administration at that time -- and I may not have the words exactly right, but it's very close. He said, "Even though we don't like the way you part your hair, it doesn't mean that we'll throw you out of school, but we could." So that was the way we

were greeted. He later became President, and I don't really think that was a philosophy that he continued with, but that was sort of an example of how the administration controlled the student body.

CBP: I'd like to talk to you now about your military experience. Upon graduating from PCOM in 1962, I understand you completed an internship at the Fort Worth, Texas Osteopathic Hospital in 1963, and an anesthesiology residency, as well, in 1965. Could you please describe your professional practice prior to the start of your military career?

JB: I was in a group practice in which the size of the group varied through the years, from 1965 until -- I left in 1974.

CBP: Was this in Texas?

JB: In Texas -- in Fort Worth, at the Osteopathic Hospital. It was strictly anesthesia, and we -- at that time -- covered some other community hospitals. In fact, I used to go with some of the general surgeons and some of the orthopods, and they would fly their own planes to some of the smaller towns outside the Dallas/Fort Worth area, and I'd give the anesthesia, and they'd do the surgery, and turn the patients over to the general practitioner that had the hospital, and then we'd fly home. Those

standards of care, of course, would not be acceptable today because you don't go in and leave like we did. I can even recall going out to family practice or general practice doctor's office and giving anesthesia while he took out tonsils with ether. That would not be sensible by any means today! [laughs] But we did it, and we didn't think too much of it. That was just kind of the way it was done. But in addition to working there at the Fort Worth Osteopathic Hospital, we would cover some other facilities in the mid-cities area, as well as in Dallas, to help with anesthesia. And the group varied from two to five while I was there.

CBP: Beginning in 1967, D.O.s were conscripted into military service for the Vietnam War. You were a qualified physician at that time. Why weren't you drafted?

JB: Probably because of the size of my family.

CBP: They didn't draft people with two children?

JB: Then tended not to. I have four children. I'm trying to think now when the last one was born. She's thirty.

CBP: So that would have been 1966-1967.

JB: So I had had three by the time they got around to it -- too many to draft.

CBP: Was that a concern at the time -- that you would be drafted?

JB: Yes, I was concerned. And at one point in that time, I did get a letter saying that I needed to go for my physical for the draft. And I think that I wrote to the Board -- that was here, in Pennsylvania -- and again told them what I was doing, that I was providing anesthesia. At that time I was practicing anesthesia, and how many kids I had, etc., and I think that they said I didn't need to go for the physical. So I missed it. But when they started drafting D.O.s, we had interns at Fort Worth that were being drafted at that time.

CBP: Taken out of their internships?

JB: No, they waited until they finished, and then they went.

CBP: Do you ever regret that you weren't there for that?

JB: At that time I didn't want to go, particularly.

CBP: Personal or political reasons?

JB: I think it was both. Number one, I was not enamored with the military because I had spent two years in the ROTC program at Gettysburg, in the Army ROTC Program, and I hated it. I couldn't wait to get out of it. I was telling these students today that when I told my wife that I was going to join the Navy,

she thought I'd completely lost it because she knew that I'd disliked my previous experience -- however small that was. But I think time and maturity and things just changed, and when I met this recruiter at a Texas Osteopathic Medical Association meeting, it really sounded fascinating. And at that point in time, I was getting somewhat disenchanted with what I was doing in anesthesia with the same four green walls day in and day out, and things then were changing a bit in medicine. I just wasn't happy at doing what I was doing as I had been, so this was a good opportunity and it sounded fascinating, and I joined the Navy.

CBP: Well, that was my next question, which you just answered. Could you just explain to me what it means to be a flight surgeon?

JB: A flight surgeon in the Navy -- well, in the military, in general -- it's pretty much the same sort of thing. It's not that you were doing surgery or general surgery, but that you were taking care of aviation medicine-type problems, and that you're assigned to an aviation community and involved in not only the medical aspects, but also the psychological aspects of that community and trying to get to -- for a young flight surgeon, going with

a squadron, you want to get to know all those pilots -- all those aviators well -- and be able to detect if they're having any problems maybe at home -- whatever the case may be. Because you don't want them flying if they have distractions. And then you deal with aviation medical things, such as barotrauma and things that deal with altitude and inner ear problems -- those sorts of things.

CBP: But you did have to learn how to fly?

JB: Yes. At that time -- and it still is that way in the Navy -- it may change here in the not-too-distant future because of funding problems, etc. In the Navy -- and we were the only service that did that at the time. It's a six-month program, and during that six months, you had an academic portion, where you studied aviation specific-type problems in the different clinical specialties, including psychiatry and opthamology and otolaryngology, cardiology, etc. Then you went through the basic flight programs that all Naval aviators go through, up to the point of solo, and that's the end of your training program. But I did go through that, and I soloed a T-34, which was a single-engine training airplane. They have a newer version now. And for me, at that point in time -- it was one of my

JB: biggest accomplishments. When I got out of that plane after soloing, I told my family that I think that I was more pleased and feelings of accomplishment were greater than when I got my diploma here, and I thought that was something. [laughs]

CBP: Did you ever fly again? Were you a pilot?

JB: Not solo. I never went out and got my private license. I flew again with other people, but not solo. At the time that I went through this, my classmates for the most part, were all at least a decade junior to me.

CBP: These people had gone straight into the military?

JB: Yes.

CBP: How were you received by them?

JB: Pretty well. At first they weren't so sure because I was older, and actually came in at a more senior rank than they did. But I got along very well with them, and they were very helpful and I had a good time.

CBP: When you started your training in the Navy, did the allopathic trainees or allopathic instructors know that you were a D.O.? And if so, were you treated any differently because you came into the program as a D.O.?

JB: I don't think that I was treated any differently.

CBP: Did they know you were a D.O.?

JB: Yes, they knew I was a D.O., and to my knowledge, I wasn't aware of anything. In flight surgery training, all these students -- I was the only D.O. in that group, and the rest were all allopathic students, and as I said, they treated me very well and were very helpful when we'd be studying for certain courses and things that I hadn't seen for ten years, or worked on, they would help. We would get together and study as a group. I had never been very athletically inclined, and doing the water survival training, I had a couple of them -- but one in particular -- allopathic physicians that worked with me. Some remedial-type stuff to help me get through that. And he, by the way, went on to be a dual designater, both physician and an aviator, and is now an orthopedic surgeon.

CBP: Throughout the experiences in your military career, have you ever felt any prejudicial or differential treatment because you're a D.O., or have you witnessed any such treatment towards your osteopathic peers in the military?

JB: I had this one student ask me a question like that just a little while ago, and personally, I think

not. However, I do know during the earlier years, our osteopathic students were unable to get residency programs in the surgical specialties.

CBP: Are you talking about within the military?

JB: Within the military. But the reason was not the military. The reason was the civilian organizations that controlled residency programs, because they told our military Program Directors that if they took an osteopathic position, they wouldn't accredit their programs, so they were kind of blackmailed. And that took quite a while to overturn.

CBP: Do you know when that turned?

JB: It hasn't been all that long ago. Maybe in the last ten years. Or it could be a little bit more than that now. I'm not sure. But again, it was not the military because we had Program Directors who were quite willing to take osteopathic students. And for the most part, in the military, you don't know what your background is, or what degree you have, unless you ask the individual where they went to school. They're all working together, doing the same thing. Our osteopathic students -- graduates if they're in the military -- have done very well, and I know that early on, we had some Program Directors who were in the surgical specialties, who would have been very,

very willing to accept our D.O.s into the programs, but couldn't. So I don't think that I have seen any real bias in any way, except there, and that was not the fault of the military, I don't think.

CBP: To what extent were you utilizing OMT in treating patients in the Navy?

JB: You have to look at my career in the Navy because my first tour of duty aboard the aircraft carrier, I was a senior medical officer, and there I did some OMT. I didn't do a lot, because in anesthesia, I didn't do a whole lot. But I did general medicine on the aircraft carrier, as well as whenever we had any surgery -- I did all the anesthesia during the time I was on there. Following that tour of duty, I've been in administrative positions ever since.

CBP: When you were using OMT early on in your career in the Navy -- I'm assuming you had patients who were being treated by an osteopathic physician for the first time.

JB: Yes, probably. You would have to explain what you were doing and why you were doing it.

CBP: How were you received by patients who were seeing you for the first time, because you were the military doctor that was there for them, and here you came in with this technique?

JB: I think okay. They would question it, of course. And if they were uncertain, sometimes they were a little reticent or reluctant. But I never had any real problem with that. I had some allopathic physicians that worked for me who had good friends that were D.O.s, that actually did some manipulation that their D.O. friends taught them. And I just finished telling the students at lunchtime, that many of the D.O.s in the military that do a lot of manipulation, find that they become overwhelmed because the word gets out and you start attracting patients from all over the place. It almost gets to the point where they can't handle the demand.

CBP: Why do you think it gets so popular in the military versus in the general public?

JB: I don't know that it's any more so than in the general public, except the fact -- in the military we deal with -- for the most part, a very active group of individuals who are at an age where they tend to get structural-type problems from athletics or the type of work that they do, which is very amenable to manipulation. Aviation is a good example, if you talk to some D.O.s that are flight surgeons who know a lot of aviators sitting in a cockpit, and the way they pull G's. They really

appreciate OMT.

[end of side one]

CBP: Other than OMT, what special skills, if any, do you feel you brought to your service in the Navy, because you came in as an osteopathic physician?

JB: I'm not sure about the term 'skills.' It may be just a matter of semantics. I think it would be more in the way of philosophy than in skills, specifically in that we are taught from the beginning that you look at the patient as a whole, and you treat the individual and not the disease. So I think it's more of that type of philosophy. And now, as you've watched medicine evolve into what is happening today with managed care, and the fact that we're looking at trying to prevent disease rather than treat disease, we, as D.O.s, have been sort of doing that forever. I think osteopathy has been in the preventive medicine business for a long time, in teaching people proper body mechanics and healthy lifestyles. It attempted to do that, anyway. And now it's kind of in vogue throughout medicine. I guess for financial reasons, one of the main causes is we can't afford to continue to take

care of sick people the way we were able to, with the new technology. I mean, it's just so costly. If we can prevent the disease rather than having to intervene after you have it, we're way ahead of the game. And people are living longer, and have more chances of developing problems. So I don't know about skills.

CBP: But the philosophy. What special skills or philosophies do you feel you have acquired because of your military service?

JB: Well, I think the type of organization that the military is -- it's a hierarchy. I'm drawing a blank on a word that I'm searching for. Exposure to a whole different culture than what I had been accustomed to, previously. In some ways, military and academia are a lot alike in ranking sort of structure. The discipline aspects of the military, I think, has not been all that bad for me, even though I think as physicians we have to learn a fair amount of self-discipline along the way. But in the military, you may learn even a little more, and you're able to learn to function in that disciplined environment. The military is certainly not for everybody, and a lot of folks can't handle the authority, working under an authority. As

physicians, we have a little more difficulty with that because we're taught to be independent, self-thinking individuals from the beginning, and I know a lot of our medical doctors -- physicians -- it doesn't matter what school they graduated from -- physicians in the military sometimes have difficulty with taking orders because they're taught to give orders rather than take orders. So that's a transition that you have to learn. And I think that I've learned to do that, though I don't always enjoy it necessarily, or agree to what the superiors have to say or tell you to do. But you can state your thoughts on it, and if they still disagree, then you just march off smartly and do it. That's one of those things. And as I said, not everybody is capable of doing that. But I think exposure to different cultures and systems -- the travel part that I've been able to enjoy and experience in the military has been very good for me. And my family, too.

CBP: I've been through your C.V., and seen the list of your assignments and your titles, and how it took you from one place to the other. I'd like for you to highlight what you think have been the most significant positions that you've held, or the ones

that have brought you the most personal satisfaction.

JB: The job that I look upon as being pretty much the highlight of my military career -- and in some ways it sounds rather strange because one would normally think -- and it's kind of hard to separate -- when you're selected as a flag officer, that's definitely a highlight of your career. However, the job that I had as being the commanding officer of the hospital in Japan was the most gratifying and enjoyable of my career, for many reasons. Number one, I had a nice hospital -- a community-type hospital with a good staff. Hard-working and bright, and we had good patients, and were able to do a lot of nice things for people that were far away from their homes, and many times their family. So that's the first part of it. The second is that I was able to deal with patients on a day-to-day basis, however, not to have the day-to-day responsibility of their care. I could vicariously, through the staff physicians, ask them questions and provide comments, or sometimes maybe even advice, on how to take care of a patient, even though I wasn't clinically doing that myself.

CBP: So that part is nice because you have that interface

JB: with the patients on a day-to-day basis, where most

of the jobs that I've had since then are staff jobs where you don't interface directly with patients.

JB: And then last, but certainly not least, was the fact of living in Japan, where we were treated so well. I said we were actually spoiled kids because the community over there -- in the position as Commanding Officer of the hospital, you got invited to functions that you just would never get invited to in the United States. For instance, you met the Prime Minister because he invited you to a function, celebrating the cherry blossom season. You would go to the Ambassador's Quarters for the Fourth of July. Those types of things. So that the social aspects were really fun, and then the Japanese people themselves that we met were just great. We got to do a lot of travelling and seeing the country.

CBP: Did you have your four children with you in Japan?

JB: No. Our youngest one was in college at the time, and she took off a trimester and came over and stayed with us. Two of the others came to visit. One child didn't get over at all. And actually, that was the first time that my wife and I were without children.

CBP: How long were you in Japan?

JB: Three years.

CBP: Did you come back to the States during those three years?

JB: I came back frequently. That was an advantage for me -- and my wife could usually come, as well -- because there would be functions here that I needed to come to, either on official business or for other reasons. I came to all the alumni board meetings during that time.

CBP: [laughs] When did you start serving on the alumni board?

JB: You know, I forget now, but it's ten or twelve years ago.

CBP: Well, we'll get to that.

JB: Hale has that in his statistics. I forget now just what year it actually was.

CBP: How about the Board of Trustees?

JB: Just this year.

CBP: Okay. That's where I was getting confused. I didn't think you were on there way back when, or I would have developed a whole list of questions about the Board.

JB: No, just this year.

CBP: Are there any other comments you'd like to make about your assignments in the military?

JB: They've all been great. The one that I probably had

JB: the most difficulty getting accustomed to was my assignment in Washington, D.C. I was there for five years, in two different jobs, though.

CBP: Which assignments specifically are you referring to, when you were in Washington?

JB: I was at the Bureau of Medicine and Surgery, and then at the Bureau of Naval Personnel. I was three years at one and two at the other. And that had more to do with just the Washington, D.C. environment, I guess. We lived eighteen miles from the office, and the traffic was terrible, and there are so many people, and there was a queue for everything that you did, and I just had a lot of difficulty with that. I worked long hours, which was okay, but then by the time you got home you were so tired you didn't want to do anything else. [laughs] That was, as I said, the hardest to get used to. And all the others have been great. The experience aboard a carrier was one that I would never want to give up. That was totally unique.

CBP: How long were you out on the carrier?

JB: I was assigned to the carrier for twenty-eight months, and we spent a little over six months on one deployment, where we were gone that whole time.

CBP: And your wife was --?

JB: In California. But even when you weren't on deployment, you would be working up for the deployment, so you would go out for maybe two or three weeks, and you'd be back for a week or two, and you'd be out again. Constantly coming and going.

CBP: Did you know you would be getting into that kind of separation when you enlisted?

JB: Yes, I did. As I said, I had a good recruiter. He came to the house, actually. He talked to my wife and family, and showed a movie that was taken on an aircraft carrier. So we knew what we were in for, but you don't know exactly what it's like until you experience it. That first part was pretty tough on my wife and family. But if you were to talk with her now, I think she has no regrets, either. She has really enjoyed the military and the places that we have been assigned. I told the students earlier today, for the most part, it's where people pay big bucks to go on vacation.

CBP: Hawaii.

JB: We lived in Hawaii, we lived in San Diego, we lived in the San Francisco area, we lived in Whidbey Island, in Washington State, in the middle of the Puget Sound, Japan, Washington, D.C., Norfolk,

Virginia. So they have been pretty nice places.

CBP: In September of 1993, you were promoted to Rear Admiral. Please describe your responsibilities at that level of rank.

JB: As Rear Admiral?

CBP: Yes. What changed when you became Rear Admiral?

JB: Well, the irony is that not a whole lot changed at first because when I was promoted to Rear Admiral, I was in a position that had always been filled as an Admiral until I took it. I was the first Navy Captain to be in that job, and that was the Pacific Fleet Surgeon. After I was promoted, they moved me from the Pacific Fleet to the Atlantic Fleet, the same job -- however, in the Atlantic Fleet there are a couple more jobs assigned to it, so there is more responsibility. My primary duty is the Atlantic Fleet Surgeon, but then I'm also the command surgeon for the U.S. Atlantic Command, which is a unified command. It's Army, Navy, Air Force, Marines. And also the Medical Advisor to the Supreme Allied Commander Atlantic, which is the NATO command.

CBP: You indicated that you have more or less responsibility since you moved east?

JB: More, because I now have three commands that I'm dealing with, compared to just one in the Pacific.

Geographically in the Pacific, it was a much larger area to cover because they were responsible for not only all the ships in the Pacific area, but you had facilities. At that time in the Philippines, Guam, Okinawa, Korea and Japan . . . mainland Japan.

CBP: With all these administrative responsibilities that you have, do you ever miss the hands-on patient care?

JB: Yes, but not enough to make me want to ever return to that. Particularly these days. But as I mentioned to you before, I think one of the reasons that I enjoyed my position as Commanding Officer to the hospital was my ability to interact with patients, which I don't get to do now. And I do miss that part of it.

CBP: What's your next career move?

JB: I don't know. At this point, I have no idea. I could retire as early as this coming September, and then I don't know what I'm going to do. I'm not currently seeking employment. If something came along that looked interesting, I'm not going to turn it down. I'm not sure what I'm going to do.

CBP: How much further do you think you can go in the military?

JB: If I were to be selected for another star, then I

could spend another three or four years, or so.

CBP: New position?

JB: It would be a different position. But I just turned sixty this past October, so the chances of that, I think, are kind of slim.

CBP: You caught up pretty well, considering you had a late start.

JB: That's right. I'm not complaining at all.

CBP: [laughs]

JB: I've had a very good career. The Navy has been very good to me, and hopefully, I've been good for it. [laughs]

CBP: Apparently! [laughs] Your appointment as Rear Admiral made you the third D.O. to achieve Flag Office or status in the U.S. Navy, which is clearly a personal milestone, but also a professional milestone within the context of the osteopathic profession struggles for recognition. To what extent do you think the military and the public, which includes perspective osteopathic physicians and osteopathic patients, even know of your osteopathic background, and view you as an Ambassador of osteopathy?

JB: Well, that's a mouthful, isn't it?

CBP: It is. You can think about that. If you want I'll

put this on pause.

JB: I'm not sure how to answer that. I'm, of course, very proud that I'm an osteopathic physician, and I'm very proud of the fact that I've received flag rank in the Navy. I believe that everybody around me in the Navy knows that I'm an osteopathic physician. My diploma is visible behind my desk, so that anyone that comes in my office sees that. I've been very active in the Association of Military Osteopathic Physicians and Surgeons -- a charter member of that group -- and had the opportunity to be the President of it for a couple of years, several years back. I'm a strong proponent of osteopathy, and as far as the public, the recognition, I guess, that I get is primarily through publications from the College here, and from the AOA, and there's hardly a meeting that I attend that I don't have somebody that introduces themselves to me and says that they have been following my career through the journals of either the AOA or the College. Outside of that, I don't think there's a whole lot of publicity on it. My fellow flag officers in the Navy, and I suspect in the other services to some degree, are aware that I'm an osteopathic physician. I think the selection

of General Blanck for the Surgeon General of the Army has gone even further along those lines to let folks know that osteopathy has achieved recognition in that area. But one of the students today asked a question similar to that, and said that he was reading in the I think it was the AMA Journal -- that Dr. Blanck had been selected for Surgeon General of the Army, but it had no mention of osteopathy. I said, "Well, it doesn't surprise me, and if I were in that position, I would probably do the same thing. Why would they want to promote an osteopathic physician?" So they're just going to call him 'Dr.' I don't have a problem with that. It's kind of human nature, I believe.

CBP: I would like to ask you some questions that will be more general now, about military medical history as it pertains to osteopaths.

JB: I may or may not be able to help you.

CBP: Well, you might have some insight. These are some things that I'm trying to piece together. During the second World War and the Korean War, osteopathic physicians were not commissioned to serve in the medical corps. Why? And what role did the AMA play in policy-making for the DOD?

JB: I don't know the answer to that. I suspect that

they had a strong role to play in it, but I don't know that for a fact. I'm fairly certain that they realized later on that it was a big mistake. It was great for the osteopathic profession because during that time, the M.D.s were being drafted, and that left all the osteopathic physicians back home to take care of everybody, and they really came into their own during that time, for a number of reasons. One, they were the only game in town, so that they were able to build practices. But two, they were also able to demonstrate their skills and abilities at the same time, which just flourished. So I think it was a tactical error on the part of the AMA. If, in fact, they were instrumental in being able to, and I think they were, but I don't know for a fact. D.O.s that were in the Service then could only -- in the Navy, serve as pharmacists' mates and enlisted ranks.

CBP: In reading an issue of PCOM's Digest from 1954, I found a reference to Dr. E. Anthony Sailer, who graduated from PCO in 1932, and already in 1954, he held the rank of a First Lieutenant in the Medical Corps for the U.S. Air Force. My question is, if D.O.s weren't accepted for military medical service, how could his commission have resulted in the 1950s?

He was a flight surgeon of the Somerville Squadron Civil Air Patrol.

JB: When? 1954?

CBP: 1954. This was in a 1954 publication -- that he held that commission already.

JB: I don't know.

CBP: So there was no other way to get in?

JB: He didn't have an M.D. degree, as well?

CBP: To my knowledge he didn't. He graduated from here in 1932. I don't know if he had any other degree.

JB: I don't know. We had some folks in early years that even then had dual degrees. I don't know how that would be. We all know that there are aberrations and things that happened with administrative glitches that can occur, so I'm not sure. That's kind of like in the Royal Navy -- they had a Surgeon General that served for a number of years, and it wasn't until the death of that Surgeon General that they discovered it wasn't a male.

CBP: [laughs]

JB: So strange things can happen.

CBP: Okay. [laughs] In 1956, Congress enacted Public Law 84763 and President Eisenhower signed the legislation, which permitted the Armed Forces to include D.O.s in any doctor's draft. Why weren't

D.O.s accepted? If they were accepted as potential draftees, is my question, in reality, why were they still absent from the military until 1966?

JB: That was strictly -- again, it was before my time in the military -- but my understanding is it was strictly an administrative decision on the parts of the allopathic physicians in the military, and they were able to do that. Are you aware that there is congressional directive now that the military also has to accept chiropractic physicians -- chiropractors?

CBP: No.

JB: There is. We have pilot programs at several hospitals in each of the services. Currently we only have civilians hired. They don't have anybody in uniform. Same sort of thing.

CBP: In April of 1966, Secretary of Defense, Robert McNamara, issued a directive, ordering the military to accept D.O. volunteers for active duty commissions in the Medical Corps, and in February of 1967, after the AMA House of Delegates lifted its objection to including D.O.s in the draft, the first D.O.s were conscripted for military service. Why were the military's and the AMA's attitudes toward D.O.s different when it came to the Vietnam War?

JB: I can't answer that.

CBP: Why did they suddenly want you? [laughs] And they didn't want you a few years before that.

JB: Again, we would have to speculate. I mean, you can speculate the same as I can. My guess is that number one, they finally learned their lesson, and that they didn't want to send all their folks over to Vietnam. And number two, that war was not one that was accepted by everybody by any means. So therefore, share the wealth. [laughs]

CBP: [laughs] In 1987, the DOD issued a new policy recognizing the AOA's specialty certification process.

JB: When?

CBP: 1987. I was wondering if you could explain this policy and its significance to me, if you're familiar with it.

JB: Well, I think that I should be, but I'm not sure that I am. When they came out with bonuses -- when you tied finances with certification -- I think that's when this came about. You can't hold me to this as being factual because I don't have all the facts in front of me, and I'm just trying to recall. I believe that that's where it came from, that the regulations or the legislation was written so that

certification had to be by an AMA-approved board or whatever, and I think that they had to change that so that our osteopathic physicians who were certified by D.O. boards were eligible for the certification pay, and that's, I believe, what you're talking about.

CBP: This is going to seem like a long question to be able to ask it. In August of 1989, as required by Public Law 180, selective service sent an operational concept for a standby health care personal delivery system to Congress. This plan would induct men and women D.O.s under age forty-five within ten days of mobilization orders instead of the months it used to take under the doctor's draft. Do you know if this legislation ever went through and could cause a quick conscription?

JB: Not that I'm aware of. I really don't know what that's about.

CBP: Have there been any other significant acts or directives impacting military service for D.O.s that I haven't mentioned?

JB: I can't recall any. Anything I can think of now -- any directives that come out now are just kind of broad-based and cover any licensed physician. They don't discriminate D.O. or M.D. All the contracts

and everything that you see written now -- it always has M.D./D.O. So I don't know of any. I can't think of any.

CBP: Do you have any idea how many D.O.s were in the Navy during the 1991 Gulf War?

JB: No.

CBP: Would they have been fully integrated, as far as their duties and responsibilities?

JB: Yes. I think you can pull up those figures. While I was at the Bureau of Medicine and Surgery, I had the question asked of me a number of times about identifying D.O.s. And at that point in time, the computer system that we had available, which was not very good -- we really couldn't do it because even in the computer systems you have today -- it depends on how information is entered. They may have put it in as Osteopathic College of Philadelphia or Philadelphia College of Osteopathy. There were a number of ways that things could be entered, and trying to get that information was just impossible. I never could do it. I think that there probably -- with the newer systems -- there are some ways of pulling that out now. Bob Klobnak, the Executive Director of AMOPS, has some pretty good information, and the AOA tries to keep that up pretty well. But

I can't tell you now. I don't know what percentage. In the Navy we have around four thousand physicians. I really don't know what percentage of those are currently D.O.s.

CBP: Well, through some of the things that I was reading in the 1996 article, it mentioned that there were 331 D.O.s in the Navy.

JB: Could be. I would have thought more than that, but I don't really know.

CBP: In your opinion, is the military currently a good place for D.O.s, and why? Or why not?

JB: Again, this is a bias answer on my part. I think that the military is a good place for physicians. I think it's equally good for a D.O. or an M.D. I like the military, and I think it's a good place to be. We're going through some drastic changes just as the civilian community is going through changes. But for now, anyway, we don't have to deal with the third party payors and all the managed care aspects that the civilian community is going through, even though we are introducing managed care to the military. It's still a little different. We've been practicing, for the most part in the military, a type of managed care for a long time, but this now has even grown more so. We're contracting a lot of

the care out. Coming down in size, and I'm not sure exactly what military medicine is really going to look like in the future. But for the time being, I think it's a good place to be. I think as a D.O., it's good for a physician. You have opportunities for a variety of experiences. You're not going to make a whole lot of money, but then as I look at the reports on civilian medicine, they're taking big pay cuts as well. So I don't think it's bad at all.

CBP: If you were writing a chapter in our upcoming centennial history book about the military, which PCOM graduates, other than yourself, do you think I should highlight, and why?

JB: Well, immediately I have to say General Blanck because he has achieved the ultimate goal, as far as the military goes. I mean, there is only one Surgeon General for each of the Services. For physicians, there is only one three-star General or Flag Officer in each of the Services, and he has achieved that, and that's just an incredible achievement. If you had asked me a few years ago would that happen or could that happen, I would have been suspect that it could or would, and not necessarily because we as D.O.s are looked at differently, but just because of the sheer numbers

and competition, and us being still quite -- if your numbers are right there, three hundred and some D.O.s in the Navy out of four thousand, that's pretty small.

CBP: Yes.

JB: And in the Army, I'm sure that the ratios are probably similar. I'm not positive, but I would guess that they're similar. To be one of those that makes -- to be a D.O. out of a small group and to achieve -- becoming Surgeon General is not -- I mean, the chances are not great, and he certainly has done that. So he stands out first and foremost. Actually, anybody that makes flag rank in the military -- there are only a few in the Medical Department in the Navy -- all together, I think, there are twelve physicians that make flag rank out of four thousand. So the pyramid gets very small towards the top. And those folks who went before me -- the Navy, I guess, was the first one to be selected as a Flag Officer, and that was Lew Eske, who was a Des Moines graduate, I think. And then Hugh Scott was the second, from Philadelphia. And Ron Blanck. Was Ron before or after Hugh, in being selected? Now I can't even remember. About the same time, I think. And now we have several more in

the Army -- in the Reserves, when you count them all up -- we have a pretty good representation. Public Health Service, I guess, was the first to promote a D.O. to Flag -- Murray Goldstein was the first to achieve Flag rank.

CBP: Was he from PCO?

JB: I don't think he's from PCO. I forget where he's from. I don't think he's from PCO. But he was in the National Institutes of Health and ran the neurosurgical part there -- the program. So he was the first in the Public Health Service. We have a female now -- I'm not sure what school she's from -- in Public Health Services, also -- a Flag officer. So we're not as rare a breed as we were back when Lew Eske was selected. And the Air Force has yet to select any. I'm not sure why.

CBP: You mentioned before that you were talking to students about a military scholarship program.

JB: Yes.

CBP: Could you explain a little bit what that is?

JB: The government offers a scholarship to medical students who in turn, then, have a payback period of year for year, not including the first year of graduate medical education. So the students here that have a four-year scholarship will then be

requested to serve four years on active duty following their internship year. I think it's a great deal because they get their tuition paid, they get a small stipend between four and five hundred dollars, I think, a month, which is small these days, I guess, but it doesn't sound all that small to me. [laughs] Their books and equipment are all paid for, so I think it's really a good deal.

CBP: How many PCOM students are taking advantage of that?

JB: You'd have to ask Carol Fox how many we have in the program now. But there are a fair number. Last year, just in the Navy alone, I think we had twelve or thirteen. Talking with these students today, they said it varies a fair amount from class to class, as to how many students there are.

CBP: When did this program start?

JB: Well, when I was at the Bureau of Medicine and Surgery, I was on a board that helped select scholarships students, and that was in 1977. So it was, I think, even prior to that. It was right after the draft was revoked -- a few years after that -- when the all volunteer force came about, and we were having some difficulty getting physicians to volunteer, they started this scholarship program. We could get those dates for you.

CBP: I guess Carol would have that information.

JB: I think she probably does. But it's from that era.

CBP: Could you please describe your role as the Alumni Association Board's military representative to the College Board of Trustees? How are you different from any other Board of Trustees?

JB: Well, I have to correct you, I guess. I happen to be in the military, but I am not the Alumni Board's military representative to the Board of Trustees. I am just the representative from the Board of Trustees of the Alumni Board. I may need to say that again; I'm not sure I said that right. I got on the Alumni Board as the military representative. Then, after I served as President of the Board and became past President -- the Alumni Board has a representative to the foundation and the College Board. When that became available, I was nominated and elected to that position, so it was just --

CBP: So it had nothing to do with your military role?

JB: It had nothing to do with military. I'm just the Alumni Board Representative to the Board of Trustees.

CBP: Okay. Then let's go back to your role in the Alumni Association Board as the military representative for twelve years, was it?

JB: Yes, I think.

CBP: What was your role as the military representative to the Alumni Association Board?

JB: Well, it's probably a couple pieces to that. One is to represent the military alumni to the Board and visa versa. Keep the military alumni informed of what's transpiring at the College. That was done primarily through correspondence that we sent out from here. And I would keep the Board informed of what was going on in the military and try to keep them up to speed on some of the things that were going on with members, but a lot of that's done, of course, through Hale and his office. Speak with other alumni at different meetings that I would go to, and tell them about the College. Encourage them to come visit, etc.

CBP: Two more questions for you, to wrap this interview up.

JB: Okay.

CBP: In your opinion, what has been PCOM's most significant contribution to the profession?

JB: I guess first and foremost is their product. As best I can tell, we have some really good graduates who have contributed to the health and welfare of our nation, through their medical practice. And we

have a lot of graduates in some very key positions, both in government and in education -- both osteopathic and allopathic. So I think that would be the key contribution.

CBP: What do you see as the primary challenges and goals for PCOM to meet as it approaches its centennial and the 21st century?

JB: I think the biggest challenge is going to be in dealing with the changing health care community, changing the curriculum as it needs to be changed to focus more on the ambulatory care by its inpatient care. How we're going to get the students the experience -- the clinical experience that they need -- and meeting those challenges that they'll be facing as they go out into the communities. Funding is always going to be a problem, and I think it's going to be even more so. In the past, we relied on a lot of federal grants. I'm not speaking just of PCOM right now. I think just medical schools in general are all faced with that. Here in Pennsylvania, the College has always received some funding from the State, and that has declined, and they're never really sure whether it's going to continue or not. So they have to become more self-sufficient. At the same time, I don't see how you

can raise the tuition much more because it's so high as it is. Many students can't afford to go to school without some kind of support, such as the Health Scholarship Program that the Armed Forces has. I think those are the major challenges we'll be facing. The changes to managed care. The role that these big corporations play in governing health . . . the way health care is provided. I told the students today that -- you know, we talk about managed care and managing the health care of our patients, but insurance companies and federal agencies, etc. are managing physicians very much, as well. So we're all being managed. And not always necessarily the way we want to be. I think that's the challenge -- the biggest challenges that we have to face -- in trying to keep up, or staying even ahead of those changes, and hopefully, being able to influence the direction that health care is going, rather than having to react to it.

CBP: That concludes my prepared questions for you. Is there anything else you would like to add to this interview?

JB: Well, right now I can't remember the things that I had thought about early on. I believe you've probably covered everything. I think so, anyway.

CBP: All right. Well, thank you very much.

JB: You're very welcome.

End of Interview

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