1996

Edwin H. Cressman Oral History

Philadelphia College of Osteopathic Medicine

Interview with Edwin H. Cressman, D.O., by Carol Benenson Perloff for the Philadelphia College of Osteopathic Medicine (PCOM), March 28, 1996.

PERLOFF: Dr. Cressman, could you state your full name, date of birth, where you were raised, and where you currently reside?

CRESSMAN: [redacted]

CBP: Where do you currently reside -- your address?

EHC: My address as a boy do you mean?

CBP: No, now.

EHC: [redacted]

CBP: Dr. Cressman, what made you want to pursue a career in osteopathy?

EHC: The fact that we had as our family physician, an osteopathic physician. And so my parents choosing my occupation -- I didn't choose it. My parents did. But they convinced me that this was the thing for me to do.

CBP: Were any family members in the medical profession?

EHC: No.

CBP: Why did you select PCOM, or at the time PCO, for your education?

EHC: Simply because it was located in Philadelphia, and I could travel back and forth on Philadelphia trolley cars.

CBP: Did you live at home?

EHC: I lived at home. And, of course, having to economize, going away to college made a big difference in the cost, although the cost at that time was infinitely smaller. I suppose inflation figures might determine what that true cost would have been.

CBP: Where in Philadelphia were you living with your family?

EHC: On 11th Street, between Tioga and Verango.

CBP: Which trolley were you taking down to the campus?

EHC: I took a trolley down to Spring Garden Street, and that trolley ran on Germantown Avenue, down to Spring Garden Street. And I walked across Spring Garden Street to 19th and Spring garden, which was the location of the college then.

CBP: Is that the 12th Street line coming down from Germantown? The 23?

EHC: Yes.

CBP: Could you describe your recollections of the building at 19th and Spring Garden -- both the school and the hospital?

EHC: Yes. On Spring Garden, at 19th, were three brownstones that had been big homes. Spring Garden Street was always a street of big homes. And there were three of these brownstones. The one on the corner was college, the one next to it was college. The third one was the dormitories for student nurses. The hospital was behind the brownstone on the corner.

CBP: The hospital building, however, was added after.

EHC: Yes. That was just a simple brick modern building.

CBP: Modern for the .

EHC: Well, modern compared to the brownstones, which were -- yes.

CBP: Do you remember how the building was laid out -- the school building?

EHC: Yes. The freshmen class met in a big corner room on the first floor. There was another classroom on the

second floor. Behind these two classrooms were offices and some laboratories.

CBP: How about upstairs?

EHC: Upstairs likewise. I may not be accurate about the laboratories, but I think laboratories behind the classroom in front.

CBP: The hospital was up by the time you entered?

EHC: Oh, yes. Yes.

CBP: Could you tell me some of the highlights of your educational experience at PCOM in the 1920s? Courses, professors, clinicals, exposure?

EHC: Well, my first exposure was to Henry Vergara. He was from the Philippines. He had a medical degree in the Philippines, but he could not practice in the States with that degree. He was entering the sophomore class, and he was the first individual I met as I walked up the steps of the brownstone to enter the -- the first floor was really above a basement. There was a basement below the first floor, really. This doctor -- we called him Dr. Vergara, because he did have a degree in the

Philippines -- was a student who also taught. He was a teaching student. He taught the subjects.

CBP: What were some of the other highlights of your educational experience?

EHC: Well, the first really highlight was the histology laboratory. In those days, the college supplied the microscopes. We did not have to purchase our own microscopes. We got out a microscope when we entered the laboratory -- a microscope to use in the bacterial laboratory, and also in histology. I immediately liked histology. It became a hobby. It made me feel very important because I could take a little slice of tissue from any part of the body and identify it and say, "It is this. It is kidney, it is liver, it is spleen, it is muscle." And to be able to do that seemed, to a boy -- and I was only a boy then -- seemed a great accomplishment. So it became a hobby. And it remained a hobby throughout my life. I taught histology nearly my entire life, after I had graduated.

CBP: Who taught that histology course that you took?

EHC: I don't remember. You could get that from the catalog from that date.

CBP: Could you describe your clinical training while you were a student at PCOM and comment on the strengths and weaknesses of that part of the curriculum?

EHC: I thought we had good clinical training. We didn't see patients in the relationship of physician to patient until we were in, I think, the senior year, when we worked in the out patient department clinics. From the beginning, in our freshman year, we would use an operating amphitheater as a teaching amphitheater to teach surgery. One of the highlights that I always have recalled afterward was seeing my first surgical procedure. And in those days, before there were any antibiotics, if a child had an upper respiratory infection, mastoiditis was a complication that would occur to some of those children. And the mastoid would be infected. And when it was, the bone had to be opened by hammer and chisel to chisel a hole in the mastoid bone behind

the ear. This was the first surgery that I saw. Just a tiny youngster, there on the table, and a surgeon with a hammer and a chisel going into his head, into the mastoid bone. I got up and left. That was my first surgical experience. But it isn't long before you overcome your inability to tolerate surgical procedures. You see a few, and then you don't think of them even as patients. You think of them as surgical procedures.

CBP: Where were the out patient clinics that you received training in as a medical student?

EHC: On the first floor of the hospital building were offices, a dining room for the nurses and interns, and cubicles, where the students would meet their patients whom they'd be assigned to.

CBP: Were you supervised?

EHC: Oh, yes.

CBP: Were you supervised at all times?

EHC: Yes.

CBP: Were there any other clinic settings where you gained clinical training, other than the hospital

that was part of the school?

EHC: We went to other colleges and their hospitals, and particularly Lankenau, because that was not associated with a college, and we were tolerated there. If we went to the University of Pennsylvania and the students at the University of Pennsylvania discovered those DOs in the amphitheater, they chased them out. But we'd get chased and we'd come back again.

CBP: When you were at Lankenau, were you observing certain procedures or were you actually treating patients in a clinic setting, the way you were ?

EHC: You couldn't treat patients there. Lankenau was a big hospital. There was a place on Girard Avenue -- not where it is located today. I'm trying to remember the name of the surgeon -- this particular surgeon went all day doing surgeries, one after another. He would do the important part of the surgery, and then they would wheel him out and a student surgeon would finish up and sew up -- close

up, you'd call it. Their operating amphitheater was white marble. White marble benches. Quite an attractive place. I'm trying to think of the name of the surgeon because he was an actor on a stage. He would remove a huge tumor and toss it to the intern who was to take it to the pathology department. And it being slippery, it sometimes would be dropped. But that was a part of his showmanship. If you could get in the front row -- you were really beside the operating table if you were it he front row because the table was brought right up to that front row. The front row was usually occupied by residents or interns of Lankenau, and that was taboo to sit in the first row.

CBP: Were there any other hospitals besides Lankenau, where you would sit in and watch procedures?

EHC: Yes. We went to Hahnaman. Quite often we went to Hahnnaman. They're the principal ones. Over on 9th Street.

CBP: Pennsylvania Hospital?

EHC: No. At 9th and Chestnut.

CBP: Jefferson?

EHC: Jefferson. We went over to Jefferson. They had a huge amphitheater there at Jefferson. But we would be escorted out by their students frequently and come back again. But we went over there -- they had teaching clinics in their amphitheater there. Not surgical clinics, but the case being taught by a surgical. There were surgical and non-surgical teaching clinics, and we went there to visit that amphitheater to hear some of the top ranking physicians in the City of Philadelphia.

CBP: In looking back to the day you started to practice medicine, in what way or in what ways could your education at PCOM have better prepared you?

EHC: Better prepared me than some other preparation at another college?

CBP: No, not compared to another college necessarily. But when you graduated and you were ready to practice medicine, in what ways did you feel you might have needed more education or a different type

of education? Or did you feel perfectly ?

EHC: I never felt that I needed more education. I felt that I was adequately prepared, particularly if we had an assignment as an intern in that hospital. Because we had an out patient assignment which was unique. It involved the out patient clinics, where patients were coming in and going home again in visits. But we also went to patients' homes. Poor people in South Philadelphia. It was a time when children were delivered in the homes. And it was believed and proven by statistics that they were safer from infections. Infections as complications, that there were more infections if they were hospitalized for their delivery. The big clinic in Chicago -- the head of that big clinic -- had gathered statistics to prove that deliveries in the home were safer. And so you were given a sterile pact, which you put in your car, and went to the home to deliver the baby.

CBP: Was this while you were a medical student or an intern?

EHC: You went as an intern, but the intern would often take a medical student along with him. And between the two of them they would deliver the child. We got a lot of obstetrical experience that way. We got a lot of treatment of infectious diseases that way. Infectious diseases where patients were not hospitalized. We had key individuals in certain neighborhoods in South Philadelphia, and we would go down there with our bag and report to this individual. She would know who in the neighborhood needed medical attention, and would take us to them. It was an area of little one-room-to-a-floor houses, usually three stories high, but it would be three rooms.

CBP: They're called trinity houses.

EHC: Yes. The one that fronted on the street had a certain number on that street. Behind that would be these tiny little houses. The first floor was always a living room, and the second and third floor would be bedrooms. No bath. On the first floor, a little range, where they literally lived, except for

sleeping time, in one first floor room, with a little range for heat, and a pipe that went up through the ceiling, and the rooms above got their heat from the pipe that went up to the roof through those . They were the kind of houses where we would go, particularly these such-and-such a number street -- number one. Number one would be immediately in back of the house, and number two -- one, two and sometimes three of these tiny homes were located behind the one that had the actual street address.

CBP: What kinds of things were you treating there?

EHC: Mostly they would be infectious diseases. Because they then were bed patients. They could not come to the clinic. So we were treating mostly acute illness. And that, of course, gave us lots of experience. We were seeing infectious diseases. I became considerably interested in infectious diseases, too, because they fascinated me. You could look in a throat and make a diagnosis of diphtheria, for instance. While diphtheria doesn't

exist today, then many died of diphtheria.

CBP: Was there a treatment for it then?

EHC: No specific treatment.

CBP: Then what did you do for a patient whom you diagnosed with diphtheria?

EHC: Well, we treated the or manipulative treatment, with the idea of helping or stimulating their own immune reactions. So we had something wee could do. And, of course, general care of an infectious patient. But infectious diseases were hospitalized. The city provided a Hospital for Contagious Diseases.

CBP: Where was that located?

EHC: Front and Luzerne. It was a whole city block. It was the block method of isolation of patients. The block method was a hospital building for diphtheria, a hospital building for scarlet fever, the more serious of the infectious diseases. And in order to prevent contagion spreading, when the diagnosis was made in the home, the patient was often taken to the Hospital for Contagious Diseases, called the

Municipal Hospital at Front and Luzerne. Now, we went there as students for training experience. That brings me to telling you about Typhoid Mary, because she taught us infectious diseases.

CBP: Can you give us her name, please?

EHC: Mary Patton Hitner. She would arrange for the groups -- which students were to go on a certain day -- made those arrangements. In fact, she was responsible for acquiring permission for osteopathic students to go there. In those early days the medical students didn't look upon osteopathic students as physicians in training at all, and there was that antagonism between the two professions. But she had the ability -- we thought she was a society lady, which she may have been -- I don't know -- but she was a doctor of osteopathy. So we would go there, and I can still remember the two buildings that the students always went to as groups. There were physicians assigned duty in each of these buildings. More than one physician. They were probably -- those staff physicians there were

probably backed up by student physicians or graduate physicians who were going there as a part of their intern training, perhaps. But in diphtheria, a membrane forms in the throat. If a membrane is small and it's not a severe case, the membrane is apt to be small and just in the throat. There comes a period of time when that membrane separates, and when it separates, it's a loose membrane that blocks breathing. It was the time when Chevalier Jackson had developed his scope. He developed the bronchoscope primarily to remove foreign bodies that children would swallow. And when he developed the bronchoscope, he would then have to produce a tool for each of a number of procedures of objects. If it was a safety pin, for instance, that was in the bronchi of a child, he produced a tool, that through the bronchoscope, he could close the safety pin and pull the safety pin out. And if it was another object, he would have to have a different kind of tool, and he was progressively developing these tools, and he

developed a tool to grasp diptheretic membranes that were down in the bronchia tubes. The bronchoscope was put to great use in the diphtheria building up there at the Hospital for Contagious Diseases, and the resident physicians there were trained in its use and could remove those membranes because when the membrane separates at a certain number of days after the onset of the disease, they must immediately go down and remove it because the child is choking to death because of the blockage of the bronchial tubes. So he developed a tool to go down there and -- a grasping tool -- so that he could pull the membrane out through the bronchoscopic tube. We didn't see actual removal of membranes because that can come any time within twenty-four hours, and instantly a physician has to remove that membrane. It's almost like clockwork because a certain length of time, the membrane develops and then a certain number of days after the onset of the disease, the membrane becomes loose and must promptly instantly -- that may be any time -- night

or day -- remove the membrane. We saw bronchoscopes and a demonstration of how they are used there for the first time. That was the beginning of the development of the bronchoscope. When a case was admitted to one of those hospitals, the diagnosis before admission was perhaps scarlet fever. It was admitted to the scarlet fever building. But the physician in charge of the scarlet fever building would examine it to confirm that diagnosis. One of my groups at the time -- we went there several times. But on one occasion I was to see a scarlet fever case being admitted, so the diagnosis was demonstrated. We saw the eruption. Forever after you would know thee scarlet fever eruption. I would know today a scarlet fever eruption, although there's no scarlet fever. [laughs] There's no diphtheria. Unless the immunization procedures are neglected, these diseases no longer exist. And if they do, of course, penicillin is instantaneously effective in scarlet fever.

CBP: Given the perspective you have from your years on the faculty, could you describe how the curriculum has changed since you were a student in the 1920s? Any general trends or changes in the education or specific?

EHC: I think that you would get more detail of that from perusal of the catalogues of certain years. But the teaching of basic sciences -- the anatomy and physiology and biology -- micro-organisms has been minimized. They completed very quickly, and go on to clinical education earlier in the educational plan. That, I think, is the chief difference that I see.

CBP: Do you feel that the medical students are getting enough of that basic science -- education?

EHC: No, I do not. Because I think that the basic sciences are the foundations upon which a student or a physician can build or develop his knowledge. That plus the clinical contacts with patients. After having considerable basic science education, the actual practice so that the student has the

relationship of physician to patient. But they get sufficient, I think, of the educational training in the patient contact area, but I think there's been a sacrifice of basic science teaching.

CBP: By 1920 all graduates of approved osteopathic colleges had received four years of instruction as did their M.D. counterparts. However, the struggle for professional recognition was ongoing. What were your perceptions of these struggles during the 1920s and over the decades to follow?

EHC: Well, when I was a student, and immediately after I graduated, we did not have -- when we took the state licensing examination, we did not have the privilege to use drugs. At the time I was studying surgery with the idea of becoming a surgeon, which I never pursued, except to the extent that I took the surgical board and was licensed to practice surgery. But when I acquired that license -- and incidentally, mine is number one surgical license. Then I was permitted to use drugs. That permitted me to use drugs. Although osteopathic physicians,

while they were not permitted to use drugs, used a few necessary drugs. The value of drugs was not only minimal, but the patients got well in spite of the drugs that was in use in those days. For instance, purging with a dose of mercury -- -- mercury. Well, of course, the body throws out that poison, and you poison the patient to have an evacuation. Why, then that is illustrative of the kind of medicine, and that is a reason for homeopathy becoming very important, and more important in some cities than in others because of the location of the homeopathic colleges, such as Honnoman. Homeopathic medications -- they didn't have the side effects. I can remember my family -- my parents -- choosing homeopathy for that reason. My mother had her children at home which was usually the case in those days. It was a homeopathic physician whom she had. And, of course, when she called the physician for treatment of an illness of one of us, we didn't mind taking the medicine because to swallow or to swallow

some sugar pills that tasted good -- the sugar pills were very acceptable to the child. From homeopathy, my family went to osteopathy, which was at the time a natural change for a lot of people.

[end of side one, tape one]

CBP: Dr. Cressman, what steps did PCOM take to advance the acceptance of its graduates in the medical world?

EHC: These are complicated questions.

CBP: You can pass if you don't think you can answer it. But if you can help me out on that, these are some of the gaps I'm trying to fill.

EHC: I would have to give it considerable thought. The first big step -- the major step, of course -- was the licensing. Licensing had a separate board because we were not accepted for the licensing examination by the medical board. We had not graduated from the medical school, and the M.D.s controlled the board. You had to be a graduate of

an accepted medical school in order to take the examination. So the first step was -- the best way to overcome that was to have our own board. That was obtained very early in the century. An osteopathic examining board.

CBP: What role did PCOM have in establishing that board?

EHC: Founder. What was the founder's name? The founder was the principle instigator in obtaining that board.

CBP: Are you referring to O.J. Snyder?

EHC: O.J. Snyder. Yes. My mind sometimes gets fuzzy about names. That was early in the century. When I entered the school, there was a board -- a separate osteopathic board.

CBP: Are you referring to an examination board in order to practice?

EHC: Yes. You took a state examination, and the member of the examining board are those who administered the examination, were osteopathic physicians, you see? The requirement to take the board was graduate of an osteopathic school. In fact, an M.D. couldn't

take the board -- the osteopathic board. We couldn't take their board; they couldn't take ours.

CBP: I'd like to talk to you a little bit about student life when you were a medical student. What were some of the highlights of your social experience at PCOM?

EHC: There wasn't much social activity as such that was institutionally instigated. But there were fraternities -- sororities, I presume. We took, as students, females when the medical schools did not take females. In the City of Philadelphia there was a separate college for females. And the reason for the organization of such an institution was that the females decided they wanted to be trained as physicians and recognized and examined as physicians. They couldn't get into the medical schools. They wouldn't be admitted.

CBP: Why was the osteopathic world receptive to women?

EHC: Well, I don't know. I presume because the osteopathic world at that time had been deterred from practice in every possible way by the medical

schools, so that they had to have their separate schools, and with the development of separate schools, of course, came separate examinations for certification. We also took blacks when blacks had the same difficulty getting into the medical schools. If you were black maybe you didn't get in. But there were blacks in my class -- my graduating class. There were females -- a half a dozen females -- in my graduating class. At that time you wouldn't have seen any blacks or females at the University of Pennsylvania.

CBP: But why is it that osteopaths were open to allowing blacks and women in?

EHC: Because they were a minority. And being a minority, they sympathized with other minorities. So immediately they didn't have to take them. We had adequate enrollment so I don't know whether that was ever a consideration or not. Inadequate enrollment without taking the minorities, you know? But I don't think that was the case at all. My graduating class was approximately sixty-five, which in those

days was a large class.

CBP: I actually did a little research on your class, and the Class of 1926 contained either seventy-six or eighty graduates, depending upon what source one looks at, and it contains roughly eighteen women. So eighteen out of seventy-six were women. Close to twenty-five percent. Which changes considerably later on, after the second World War, when it drops.

EHC: I just think that's pure accident that my class had so many women in it. I wouldn't have known, of course, entering as a freshman at the time my class entered, whether or not there had been any organized effort to obtain females or blacks or whatever.

CBP: When you were a student, I understand you lived at home. Was that the norm, for students to live at home and commute? Or if they were not from Philadelphia, where did they live?

EHC: No, it was not the norm because the majority -- well, my class would have had a greater number of students from the local area as any college might. But the students from my class came from states all

over. New England, New Jersey. They lived in rooming houses in the neighborhood down there.

CBP: The neighborhood near the school?

EHC: Yes. And, of course, if they joined a fraternity, there would be a fraternity house, and then they'd move from a rooming house to their fraternity house and live there.

CBP: Were many of the students married during your time as at student?

EHC: Do you mean got married?

CBP: Yes. Either married before they became students or were they married while students.

EHC: When you say many, no. Not many. We had one student. A middle-aged person. She was gray. I don't know how old she was. Her husband had died. She had a child or two to raise, and she applied for acceptance. It would have been difficult for an older person to get into medical schools and so on. What was her name? You'll see it in the catalog.

CBP: In your 1926 yearbook, class historian, Paul G.B. Norris wrote, "open warfare was pledged on intra-

class hostilities and their disruptive denouements." What were the hostilities or rivalries among classes?

EHC: I don't remember open warfare class hostilities.

CBP: What was the class rush?

EHC: Oh, I think that was an expression that was used when there were several fraternities, and the rush was a rush to obtain members for their fraternities. Some students got no invitation perhaps to a fraternity; some got several. That was called the rushing period. It was a week or a period of time early in thee freshman year when they were seeking members for fraternities.

CBP: Were there any other freshman traditions that you remember?

EHC: No.

CBP: Do you remember something called caps and bands?

EHC: I think such things were worn. I don't remember, though. Since you mention it, there's a hazy recollection that such things were worn. Or maybe proposed to be worn, and the freshmen resisted. I

imagine that would have occurred.

CBP: How about Junior Spree Day? Does that ring a bell?

EHC: No.

CBP: I'd like to talk a little bit more now about specialization and practice. Could you describe your internship at PCOM from 1926 to 1927, and comment on the strengths and weaknesses of the internship program?

EHC: Well, I always felt that the internship program was excellent. We were initiated as interns by second year students who were usually -- they had completed one year of internship and were working on some specialization. At that time it was usually surgery. Our preliminary introduction to hospital practice was to have been escorted and instructed by the second year men. There was nothing formal about it. There was a room in the hospital where the visiting doctors -- when they would come in -- would leave their coats and hats. It was the same room that the intern residents used as sort of a meeting room -- a congregation room. So a lot of contacts -

- that is, verbal contacts -- asking questions of staff members as they would come in about the patients that they were to see would occur in that room. Sort of an opportunity to -- you were going to visit these patients with this doctor whose patients they were. And you would report to the doctor their condition before he had seen them. He would give you whatever instruction might be necessary or required, or just purely for instructional educational purpose. That was sort of a get-together room. Have you yet heard of D.S.B. Pennock?

CBP: Sure.

EHC: He liked to come in there. In that room we would sometimes play cards, and we would have a penny ante game, you know? Poker. Pennies. He was a very casual person. He seemed to have all the time -- he desired for any purpose other than patients -- that he wanted. He would sit down there and join the game, play penny ante. A man who had the biggest practice in the hospital was sitting playing penny

ante with the interns.

CBP: Could you describe a little bit more what your responsibilities were as an intern?

EHC: Well, there were certain services, and you were assigned to a certain service. You were responsible for visiting, examining, checking the patients, putting notes on a chart. Your own interns' notes, separate from the practicing physicians' or nurses' notes. But you were assigned the surgical service, medical service, obstetrical service, out-patient service. That's about it. That covers it pretty well.

CBP: Between 1926 and 1937 I understand that you were an Associate to Dr. Sterrett in Urology.

EHC: Yes.

CBP: To the best of your knowledge, was PCOM at the forefront of this specialty and if so, how?

EHC: At the forefront of? Do you mean among osteopathic colleges and hospitals?

CBP: Yes.

EHC: Yes. I would say yes, that it was. He was an

excellent urologist. I attached myself to him after graduation, to study urology. I was headed for urology and urologic surgery. When I switched to dermatology, I had reached a degree when I was beginning to do surgical procedures on my own in urology. At that time, urology -- and in the medical profession in some of the schools, too -- was associated with dermatology. Dermatology had not yet separated -- well, maybe a little before that dermatology had separated and had become important enough to be a separate specialty. We didn't have a dermatologist as such, so that my choice was to have been the first and only dermatologist, or certainly a specialty man in urology. I became interested in dermatology. Because the clinic that we had was a clinic for out patients in urology and dermatology. You see, they were combined as a clinical practice at the time.

CBP: What was the linkage between urology and dermatology?

EHC: Just merely a linkage of convenience.

CBP: Related diseases?

EHC: No, not related to diseases, but just simply because dermatology had not yet reached a stage in our profession where it became a separate specialty. And, in fact, not to many years before that, the same relationship existed in medicine. We always seemed to follow medicine by a certain number of years. That we would do an imitation of what they had done. [Tape Off/On]

CBP: When did dermatology become a specialty within osteopathy?

EHC: Well, I was the number one. After graduation I had always worked in urology and dermatology. They were combined. I did general practice tapering off until in 1938, I discontinued all general practice. It was considered a part of the training. The training for a specialist -- a better method of training in the early days was to have the experience of about -- this is an arbitrary figure -- ten years of general practice, during which you might be doing special work in the special field. But you became

the specialist with that a part of your training. That was not a requirement for becoming certified, but was considered a good method of training. You can see what it might be to have general knowledge of medicine, which you have a little of, having gone to the college and internship. After internship they start to specialize. They don't do general practice at all today if they intend to specialize. But it was considered a good thing to do. I was the first certified in dermatology. My certification certificate has #1 on it.

CBP: What was the date on that -- the year?

EHC: I could go in there and look at the scroll that's rolled up. I'm not sure. We had a great deal of problems in early certification. The Board of Trustees of the profession wanted to examine us. There were three of us, myself being one of those three, who had been meeting at the time of the annual meeting of the profession.

CBP: Is this the AOA that you're referring to?

EHC: Yes. I resisted being examined in dermatology by

men who were not dermatologists. It made sense to me. I refused. And that refusal held for several years. The three of us were meeting every year. We had been meeting for three years and beyond, but eventually, the Board of Trustees -- the AOA -- decided to certify the three of us. I think it was just three.

CBP: Do you remember the names of these people?

EHC: Scardino. I can't remember the name of the man out in California.

CBP: You were three people who were practicing as dermatologists?

EHC: Yes.

CBP: Seeking certification?

EHC: Yes. So the Board finally decided that it was hopeless. We would not accept examination by other than dermatologists because dermatology was the profession -- experience. So we were certified on the basis of a grandfather's clause. In other words, the certification -- the experience for certification examination and becoming certified --

was based on having practiced for a certain length of time as dermatologists, which all three of us had. All three of us were practicing dermatologists at the time, or had been for a certain number of years. We were certified, and then we became the certifying board. When I say we, Sardino and Uhlbrick. Uhlbrick was the man out in California. at any rate, they joined with certain individuals in California who were practicing dermatology and became and established the board. I didn't become a member of that board. I was, I guess, an obstinate person at the time, and they were accepting other than the three as members of the board. The board was to be larger than just three members, and the expansion was an expansion solely utilizing California dermatologists, of which I had no knowledge of whatsoever. I thought it was an irresponsible arrangement so I was deterred from -- I was never on the board, except when that first board, which was constituted by three members -- that operated for a year or two, I think. I've

forgotten some of the --

CBP: So had you actually resigned from being on that board when they sought to expand it?

EHC: When they did decide to expand it, of course -- I imagine, if my memory is correct, it would have been the Board of Trustees of the AOA who would be demanding that it be expanded. Well, that's as much as I can remember about it, but it was a rough time in the beginning of the certification board.

CBP: Could you describe the development of dermatology at PCOM, once it separated from urology? How does it go forward from there, with you as a dermatologist?

EHC: I wouldn't have anything to add to that.

CBP: Okay. What other dermatologists at PCOM warrant recognition for their contributions as teachers and/or practitioners?

EHC: Well, I gave training to several of them. Names may allude me, but the names of the early dermatologists -- I have trouble remembering names. I gave training as a preceptor to four. He was from Detroit. The other three were from our college.

There were four that I gave at least a part of, or in two cases, all the training.

CBP: Internship training?

EHC: Oh, no. Preceptor/preceptee relationship in dermatology.

CBP: Could you explain that, please?

EHC: An individual would attach themselves to me. He would be the preceptee. I would be his preceptor. The college and hospital had dermatology clinics. He would attend the clinics and I would attend the clinics, and I would instruct him. He would be with me in my office. In addition to diagnosis and the usual treatment of skin diseases, x-ray and radiation was used a great deal in the early days of dermatology. With books on radiation treatment of dermatologic diseases, for instance, to show you the predominance of that method. And that required a good deal of instruction -- how to estimate doses, how to proceed with the actual use of x-ray equipment and the administration of the treatment. So the preceptee would learn from the preceptor just

by association.

CBP: Is this different than a residency program in dermatology?

EHC: Yes. We had no residency program in dermatology because it would require a great number of dermatologic patients in the hospital to keep a many busy, and to giving proper training. We never had that size or that number of dermatologic cases.

CBP: Has there ever been, even in more recent years, a dermatology residency?

EHC: No.

CBP: How long would these preceptorships last?

EHC: The certification board would establish what would be required, but it was not firmly established in the early days. For instance, I gave intensive training to one man. He had already been practicing dermatology. You don't have to be certified, you know, to practice this specialty. That is something to be desired, but he had intensive training with me for one years. Another had training for three years. Another had one year with me, and also some

time with some M.D. dermatologists, and so on. It was irregular.

CBP: What kind of training had you received in dermatology as a medical student?

EHC: As a medical student, just the didactic course and attendance at clinics.

CBP: How about when you were an intern, what kind of training did you receive in dermatology?

EHC: Well, as an intern, attendance at the dermatologic clinics. Remember at that time, the dermatologic clinic was also a clinic in urology. Urology and dermatology.

CBP: As a D.O., what special skills or knowledge did you bring to dermatology?

EHC: I don't think any.

CBP: Was osteopathic manipulative treatment ever used for dermatology?

EHC: Not really.

CBP: Could you describe the type of work you have done in dermatology?

EHC: Describe the type of work?

CBP: Yes. Your teaching in dermatology, your clinical practice. Your career -- how you spent your time in dermatology.

EHC: In the teaching of dermatology, of course, you present the actual patients in the clinics. But in teaching a course in dermatology, a clinic cannot provide proper training or teaching because you might not see these diseases. For instance, while is a very common disease -- you surely see it -- but yet a student might go through and never see a case of . So to show him a case of , and to show him many cases of , and different aspects of it, and different locations of the body and so on, you would take photographs -- color photographs -- which would be then utilized in the classroom to teach the students. And then you could give a regimented course that would follow in proper sequence, and you could group the diseases together, whereas in the clinic, anything may occur.

CBP: About how much of your time was spent teaching

versus treating patients?

EHC: Oh, almost entirely treating patients, because teaching is just an hour here, an hour there, if the course is -- I might add this. The disease syphilis was attached to dermatology more firmly than urology. In fact, the medical publication -- the monthly publication in dermatology -- for years and for years -- my early practice was titled Archives of Dermatology and Syphilology, until dermatology in the medical profession had, at the time, developed to the extent that the two were separated and the name was changed.

[end of side two, tape one]

CBP: Were you actually a department head in dermatology or a chairman of the department?

EHC: Yes.

CBP: Do you recall what span of time you served as the department head?

EHC: Well, I'm trying to remember when I would have

started as a department head. Department head designation is a very responsible designation. I would not offer a date earlier than 1938, when I totally gave up all practice but dermatology. And I was a department head because I was the only. I didn't have any other choice. Until I ceased to practice, I guess. Several years before 1976 because in 1976 I retired. But several years before I retired I had reduced my activities. Someone else was responsible.

CBP: Who succeeded you as head of dermatology?

EHC: Names are a problem. Someone you were with for years -- knew for years -- and the name --

CBP: Let's move on. In a survey you completed for the AOA in 1951, you indicated that you had also taught histology, embryology, acute infectious diseases, and other subjects. Was it common for the faculty to teach more than one subject?

EHC: A few did. That was uncommon. I was available, and I shouldn't say this, but I was a good teacher. I got my first teaching job -- assignment, I should

say -- DSB Pennock. We called him Uncle. That was the kindly nickname that we applied to DSB Pennock. He's the one who played cards with us, and he was our uncle, so to speak. Dr. Holden called me in -- he was the Dean -- called me in and said they wanted to do something about Dr. Pennick's course in surgery because he was frequently late, and occasionally wouldn't show up at all. But he was a good teacher. He taught me general surgery -- you know, the surgery course. The basic course in surgery. They wanted a back-up. Would I be the back-up? I was supposed to go in when he had a class, punctually, start the class. When Dr. Pennock came in, I stepped off the platform, Dr. Pennock continued, and I left the room. And that was a shock to me -- a surprise to me -- that I was able to do that. I never thought I'd be able to get up on a platform and talk and teach to students. But teaching seemed to be a natural thing for me. This infectious diseases-- how I came to teach for a few years infectious diseases. Of course, it might

seem natural that infectious diseases -- if they couldn't get somebody, might be a dermatologist because many of them are erupted diseases. Well, she broke her arm and she decided to retire. They called me. Would I take her class? They had to get somebody like that, you know? So that's how I came to teach various subjects. And, of course, histology and embryology -- histology had been my hobby. I would have been content and happy to do nothing but teach histology for the rest of my life, you see? But I kept doing that until close to the time of retirement. But the others were incidental things.

CBP: In 1957 you were appointed full Professor of Anatomy. Could you describe your teaching role in the Department of Anatomy?

EHC: Histology, micro-anatomy.

CBP: Could you describe the Masters of Science you received from PCOM in 1939? Was that degree for a particular work that you were doing?

EHC: My role as a dermatologist and training in

dermatology was the reason for it.

CBP: Was there a set degree program?

EHC: No. No, program. That's that grandfather's kind of business. You've been doing a thing for a certain length of time, you deserve recognition for having done it, and this is how a number of those Master of Science degrees in the early years might have been that type.

CBP: What was the nature of faculty-student relationships when you were a student in the 1920s?

EHC: Oh, I don't have an answer to that.

CBP: Okay. How about when you were on the faculty, what was the nature of the relationship between faculty and students, and between faculty and the administration?

EHC: I wouldn't know how to answer that type of question.

CBP: Okay. Between the time when Dean Otterbein Dressler resigned in February 1950 and Dr. Frederick A. Long was delegated as interim Dean, a Dean's Committee ran the college, and that committee consisted of you and Drs. James M. Eaton, Frederick A. Long and J.

Ernest Leuzinger. Could you describe the role of that committee?

EHC: We had regular meetings at which any problems that required decisions were presented by Dr. Long. He was the Dean ex-officio, wasn't he?

CBP: Well, he became the interim Dean after seven months.

EHC: The Dean's Committee he was on, and he really functioned as Dean at that time. There would be problems that several minds should be applied to, and that was the Dean's Committee, and we met I don't remember how often. Once a week or once a month or whenever called. I don't know.

CBP: What has been your experience in research?

EHC: None.

CBP: How do you see the osteopath's role in research in the past, the present and the future?

EHC: No answer.

CBP: What do you feel has been your most significant contributions to the profession of osteopathy?

EHC: The establishment of dermatology as a specialist.

CBP: What do you feel has been PCOM's most significant

contribution or contributions to the profession?

EHC: That would require considerable thought for a period of time to answer in any responsible manner.

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

EHC: I would pass on this group of questions, I think.

CBP: Is there anything personally that you would like to see PCOM do in the upcoming years?

EHC: Not really.

CBP: Do you think they're heading in the right direction?

EHC: Yes, to my knowledge. But for a number of years, my knowledge of what's going on at the institution, of course, has been nil.

CBP: This concludes the interview with Dr. Cressman on March 28, 1996. Thank you very much.

End of Interview

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