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Albert D'Alonzo Oral History

Philadelphia College of Osteopathic Medicine

INTERVIEW WITH ALBERT D'ALONZO, D.O. (CLASS OF 1956)
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
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PERLOFF: Dr. D'Alonzo, please state your full name, date of birth, and the place where you were raised.

D'ALONZO:

CBP: Were you raised in Philadelphia?

AD:

CBP: Where do you currently reside?

AD:

CBP: Could you give us the complete address?

AD:

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

AD: I guess the greatest influence was my father, who was an osteopathic physician, and my brother, Henry, who is also a graduate of PCOM.

CBP: I understand that when you grew up, your household included your father's medical practice.

AD: Right.

CBP: What are some of your recollections of growing up in a medical household?

AD: When we were very, very young, the three kids -- many a time we were reprimanded from making to much fuss and noise, as kids will do. But it wasn't unusual for physicians to have their offices in their homes. Especially general practitioners, like my father was. There were other physicians in Philadelphia, who were in the areas of specialty practice, that did have offices in some of the finer areas, like Pine Street and Spruce Street, access to some of the prestigious allopathic institutions. But as the city expanded, many of these individuals found their offices still appropriate in Center City because of the access by public transportation. In the 1930s and early 1940s, most households did not have automobiles, so most physicians maintained offices in their homes, and it was accessible for their patients.

CBP: What neighborhood in Philadelphia was this for your family?

AD: Well, initially, where my father was born on 1424 Frankford Avenue in Old Kensington, and then we

moved to 9th and Roosevelt Boulevard in 1935/1936, and I grew up in the Logan section.

CBP: What college education had you received prior to matriculating at PCOM?

AD: I entered Duke in 1946 and graduated in 1950, so I had my Bachelor of Arts degree from Duke University. Following graduation, I spent a short period of time outside of school and then returned to pick up required subjects for medical school at Temple University, Villanova University and University of Pennsylvania, for my chemistry, biology, zoology and physics courses.

CBP: What had you majored in at Duke?

AD: I was a history major. Liberal arts college. And a political science minor.

CBP: I understand you were an avid baseball player and that you had planned to play for the Chicago White Sox in 1950.

AD: Well, I did sign with the White Sox in 1950, and played briefly in their farm system.

CBP: What made you forsake a career in baseball for one

in medicine?

AD: The realization that the competition for my position, which was first base in those days -- there were fifteen minor league teams in the White Sox chain, and each one had at least one man playing first base or competing for the top position in the major leagues. But there were fifty-seven minor leagues in those days, too, so there was a lot of competition for each position. The major league level -- there were eighteen, consisting of twenty-five players each, so we would select two hundred ball players, and each league made the major league. The competition was good. I had a lot of fun. Even after leaving professional baseball, I played baseball until the night before I started interning.

CBP: Why did you select PCOM for your education? Or PCO, as it was called then?

AD: PCO was the top osteopathic school in the world. Our graduates were second-to-none that I could see in the immediate Philadelphia environs -- especially

in a center of medicine, like Philadelphia is. PCO held itself in good stead -- academically, clinically.

CBP: Had you considered an allopathic medical school for your education?

AD: I had considered it, but I never applied. No.

CBP: What were the highlights of your educational experience at PCO in the 1950s? Courses, professors, etc.

AD: I had a lot of great professors. Anatomy always comes to mind first, with Dr. Angus Cathie, who was an excellent teacher of anatomy, as well. A person who applied anatomy clincally, and there was a course in applied anatomy that was given in the junior year. Dr. Edwin Cressman, who was Chairman of Histology and Dermatology and Syphilology, actually, too. He gave probably the best final exams of any school level that I've ever experienced.

CBP: What was so good about his final exams?

AD: He gave you an exam on the entire course. It was

never on one small portion of the course.

CBP: Was that uncommon?

AD: Well, so often professors -- at the undergraduate level, as well -- would stress certain areas of their course material. Dr. Cressman stressed the entire course. And that was great. You knew what to prepare for. But we had excellent teachers for those that were not trained to be teachers. And excellent clinicians. William Baldwin was probably the best teacher of physiology in the city. The word gets out, so to speak. We had men come over from other medical schools -- from Temple Medical School -- to sit in on his physiology courses, at eight o'clock in the morning, three days a week.

CBP: What was so outstanding about his lectures?

AD: They were alive, they were vivid, they were meaningful, they were fun. Dr. Baldwin is still alive. He is, of course, retired. He's well up in years. But he's one of the outstanding teachers of our faculty over the years. There are a lot of others, but you don't want to hear about everybody.

CBP: No. I want to hear about the ones that you remember the most.

AD: Wilbur Lutz in Physical Diagnosis. Victor Fisher in Medicine. Let's see if I can get outside of medicine. William Daiber in Medicine. I remember most of them at their peaks -- at the zenith of their own careers. It's a shame that as a lot of persons progressed in age, they lost a little bit. But I remember in their peaks, Jake Leuzinger, head of ENT. James Madison Eaton, Chief of Orthopedic Surgery. Arthur Flack, Thoracic and Vascular Surgery. Raymond Ruberg, Neuro-Surgery. All good people.

CBP: We've recently added a few wooden boxes called "bone boxes" to our Archives collection. Could you please describe how these boxes were used by medical students?

AD: Prior to the use of plastic models, we had our own actual collection of bones -- human bones. We were assigned our boxes in the beginning of our freshman year, and we maintained those until we finished

anatomy, which was three terms later. I remember carrying them back and forth from school. And in those days, going from 9th and the Boulevard on the R bus to the Broad Street Subway, the Market Street L, and the Z bus. Hauling that, along with a lot of other textbooks was a real exercise in muscle training. I got around that a little bit by purchasing an older addition of Schaefer's Anatomy and Grey's Anatomy, and only took the chapters that were pertinent for that course of study, and I put that inside the box.

CBP: You tore them out of the book?

AD: Yes. They were the older additions. I kept the new additions. But the bone boxes were something. In fact, I just saw a picture, I think, down in Student Activities Office.

CBP: Yes. We're trying to identify the students.

AD: I know one of the men.

CBP: Everybody seems to know the same person.

AD: With the glasses?

CBP: Second from the left -- Michael Kirshbaum?

AD: Yes.

CBP: That's who everybody remembers.

AD: He assisted in physiology, I think. [laughs] I have to look at the rest of them. Maybe I will recognize more.

CBP: Do you know if the bone boxes that you used at PCO were unique to the way this school taught anatomy, or was that used at other medical schools as well, as a way of teaching them?

AD: I don't know. I don't remember. Well, I had a buddy who I went to high school with, and he went to Haverford College and I went to Duke, and then we were in medical school. He entered the University of Pennsylvania, and we used to meet. He would get on at Broad and Lehigh, on the Cross Street subway because he lived on 22nd Street, above Lehigh Avenue. Stan Greenwald. He became a general practitioner and he graduated from Penn. But we would exchange. I remember one day he said, "What do you have in the box?" [laughs] I don't think that the University of Pennsylvania had the same

opportunity to study the bones as intimately as we did. And then while we were in school, though, the Halladay spine came to be, which was an intact spine with all the ligaments attached, and flexible. They were able to study the motions and articulations of the entire spinal column as a result of that. I remember that Halladay spine was a great step forward in the study of anatomy.

CBP: Why and when was the practice of bone boxes stopped?

AD: Oh, I don't know. I don't know. A past Chairman of Anatomy might be able to tell you -- Dr. Cipolla. In fact, I just saw him in the hospital yesterday. I wish I had known. I would have asked him.

CBP: Okay. If you bump into him again and you think of it, ask him. Please share your recollections of working in the 48th Street Clinic as a medical student.

AD: [laughs] Well, we all had assigned cubicles -- booths, we called them. Clinic booths. There was a clientele assigned to each of those services. When you left, you summarized the case for the next

person who was coming on for your particular booth -- service. We had clinical instruction by supervisors who were in training to be specialists. I remember Ted Weinberg, Don Marsico, Earl Weisman as an internist, Clarence Baldwin as a hematologist/internist. All high level, competent clinicians. I remember one incident, though. I was a new senior assigned to the clinic. No, I wasn't. I was a junior. It was our first experience in clinic, and I think I was assigned to Vincent Huffnagle, who was a past Chairman of the Department of General Practice, and he's retired over in New Jersey. A patient came in and Vincent Cipolla was a surgical resident. An old Italian man that only spoke Italian -- didn't speak any English -- came in. Dr. Cipolla was trying to explain to him that he was going to have a surgeon see him, and this man didn't want a surgeon. As we came out he said, "I know what's wrong with him. He doesn't want to see a surgeon. He wants to see a teacher. He wants to see a professor of surgery. So he went back into

the booth and he explained to the man, "I'm going to call Professor of Surgery," and this man just lit up. Because the European impression of academia -- if you teach somebody -- so he called Arthur Flack, and Dr. Flack was one of the prominent surgeons, of course, and this man was thrilled. He was a different person. He accepted it. He was going to call the grande professore -- the great Professor of Surgery. And it made all the difference in the world for this patient. We had specialty clinics available that were directed by individuals in the specialties and assisted by residents. We had at least three cardiac clinics a week. One was general heart, one was prenatal for all pregnant females, and one was hypertensive.

CBP: When you said a cardiac clinic, could you explain more how that was organized? How many students were under the supervision of a cardiologist?

AD: If you had a patient that was assigned -- that was recommended to be seen -- in the specialty clinic, you went with your patient.

CBP: So you would leave your assigned booths and go with the patient?

AD: Well, it was usually -- that was available to you right in the environs of the clinic. There would be an assigned area for hematology, an assigned area for oncology, an assigned area for surgery, an assigned area for ENT, an assigned area for cardiology.

CBP: So would you examine your patient first in the booth, and then take your patient to the appropriate clinic?

AD: Yes. You would accept the new patient, come to some conclusion in your differential diagnosis, review that with your clinical supervisor, and then with his guiding you, "How would you progress, what further studies do you need, if any? Which ones would be appropriate? What is your clinical impression? Do you have any others? Do you have to clarify to rule out? What studies to do to rule them out?" And you'd be guided with the clinical supervisor?

CBP: Was this one-on-one, with the clinical supervisor?

AD: One-on-one. Yes.

CBP: Did you ever have an instance where you thought you needed to take a patient from your booth into a specialty clinic, and you got there and the specialist said, "This is not" -- for example -- "a cardiac patient?"

AD: Well, that wasn't unusual because a lot of patients would have murmurs that were physiologic. Especially in the OB patients. During pregnancy, frequently develops a functional murmur of pregnancy. Plus, there are other sounds that can emanate in the vascular system while you're pregnant. From your breast, from your thyroid, from your placenta, from your uterus, as well as from the heart. So these come into the differential. Those that had murmurs while they were carrying their children -- they were thought to be benign -- were always followed up post-natally. Six weeks post-partum, they came back to heart clinic to follow-up, to make sure that that's what the diagnosis was. So

that was reassuring, too. Probably our supervisors went the extra yard to make sure, rather than say, "Treat it as being trifle."

CBP: How would you describe your schedule for a day in the clinic?

AD: The clinic schedule was such that you made arrangements to see your patients when it was convenient for your patients, and most of the time it was morning. And you knew what patients were assigned for special clinic -- urology clinic, opthalmology clinic, ENT clinic -- so that you were able to go with your patient to that clinic and examine the patient under the tutelage of a professor or a resident was the least level we saw in the clinic for supervision.

CBP: Were these specialty clinics individual rooms, the way your booths were when you first saw a patient?

AD: Some required much more room than others. For example, ENT had a large area, and they might be seeing four or five patients. Different men, as you brought your patients in with different ENT

specialists. Ophthalmology had a room where Dr. Damon and his department had their eye equipment set-up. It was already set-up there. Cardiology had the EKG. Actually, in those days, we also had a fluoroscopic because we didn't have the capacity for echo-cardiology or anything like that. So fluoroscopic studies were routine, and EKGs were routine.

CBP: Did each specialty clinic meet each day?

AD: No. Depending on the need and the volume, some met up to three times a week. Yes. To be able to handle the numbers of patients. And that was at 48th Street and at 20th Street.

CBP: Well, that's my next question. What do you remember about North Center Hospital?

AD: North Center Hospital, when we first moved up, had such an active emergency room.

CBP: More so than 48th Street?

AD: Yes. The area was more densely populated, and we were the only hospital, I guess, between the river and Broad Street, until you got to Temple. That

covered a wide expanse. It was later that they had to close the ER to transient or carriage trade. It became a financial situation because there was a lot of charitable work performed. And that type of hospital, of course, is gone.

CBP: If a lot of this was charitable work, how was the hospital financed?

AD: We had an arrangement -- I don't know the finer details of it -- when I supervised the clinic patients in the hospital, they paid the hospital three dollars a day, which doesn't begin to cover the cost of the hospital. And that was for the visit in the hospital. You were allowed one consultation they paid ten dollars for. And invariably, when a patient came in, they saw whatever specialty felt necessary. So only one of them got paid. And that went into the clinic fund anyway. I remember also, for surgical procedures in the clinic population, that unless it was an emergency, if you went up to your limit that month, you held off and postponed that elective procedure

until the following month. Never turned down an emergency. I remember Dr. Evans saying, "Bring in the emergency, but no more electives. They'll wait until next month."

CBP: What, if any, practical experience did you obtain outside of the hospital and other clinic settings? For example, home deliveries or assisting in doctors' offices?

AD: Home delivery. My first one was as 25th and Susquehanna. There was a housing authority building. I forget the name of it. It wasn't Raymond Rosen. That was my first home delivery. We had kits already set-up for emergency home deliveries, and it included appropriate instruments for clamping and tying off and cutting the umbilical cord, and silver nitrate for the babies' eyes and a couple of basins.

CBP: Had you done any of these deliveries in the hospital before you were sent out to do it in peoples' homes?

AD: Oh, yes. We had a very, very active OB service.

CBP: Who was the head of it at that time, when you were a

medical student?

AD: Walter Evans, and then Frank Gruber, and then Lester Eisenberg. It was very active. 48th Street was always full. I remember in a short period -- a few hours -- having eight deliveries on 20th Street, where we had to take the overflow from 48th Street, as well. And they came in from all over. South Jersey. OB service was a great service, I understand. Not being a woman, I couldn't appreciate it as much, but most of the ladies who came through there had a happy experience. I remember many a great bris at the hospital, and parties.

CBP: At 48th Street or 20th Street?

AD: Both. We used to use the dining facilities -- the clinic facilities -- for bris parties. Especially if you had a classmate who had a delivery -- had a son. It was great.

CBP: When you went to do a home delivery, you were on your own? Is that correct?

AD: Yes.

CBP: Did you ever run into problems?

AD: I never did. I didn't have that many. But you're right there, and the resident was right available if you needed any help. He was probably back at the hospital working, while you were out working. But most of them made it to the hospital.

CBP: Were you giving any anesthesia in the 1950s, for the home deliveries?

AD: We gave anesthesia in the hospital, but not at home. No. Most of the deliveries at the hospital involved regional analgesia. I remember caudal was a prominent technique. Low saddle, spinal or saddle. In a pinch, you could also -- I used to love OB.

CBP: You loved OB?

AD: Yes.

CBP: Why didn't you become an obstetrician?

AD: Because I liked pets more. [laughs] I liked cardiology more. You could also do what you called a pudendal block very rapidly, and fan it out on each side. You didn't want to arrest the progression of the labor. That was the thing. I

remember Arnie Wexler.

CBP: Who was he?

AD: He was a resident. He was my first chief resident when I was an intern - senior and intern OB. Following Arnold were Joe Wolzak. I think he's somewhere in Michigan now. I had a patient come in with an aruptia placenta. I called my resident right away, and he called Dr. Gruber, who was covering. You see, all the chiefs also took clinic service, and they were supervising physicians. So he came in with this aruptia. He was there in case he was needed, but he let us do the case, which was nice.

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

AD: Better?

CBP: Did you feel a weakness in any area of your medical education?

AD: I think we were all paranoid to the point that we thought we didn't know enough. Probably the

realization that we were probably more prepared than we ever thought was your first time on night duty, as the night intern, when the whole house was yours. I always remember that Tommy Moy was the first night intern. Tommy Moy was Professor Emeritus of Anesthesiology. Thomas L. Moy. He had the first night service, and he became the first expert. [laughs] You had all the patients in the hospital, you had all OB that came in, you had the emergency room coverage. So you were making decisions all the time. We had great nurses then, too. We had a nursing school then, too.

CBP: Given the perspective you have from your years on the faculty, please describe how the curriculum has evolved since the 1950s. Any major trends or new courses?

AD: Oh, boy. Yes. The expansion of all of the subspecialties. The wonderful advances in anesthesiology that allowed surgeons to perform almost miraculous procedures now. Now we can metabolically maintain the patients through these

high-tech procedures.

CBP: How did the curriculum adjust to accommodate this increase of scientific knowledge?

AD: For example, in pharmacology, when these new types of drugs became available, it was added right into the curriculum. For example, where I might have been instructed in the sympathetic nervous system or the autonomic nervous system, and have two general categories of the sympathetic and the para-sympathetic. Now when you talk about the sympathetic nervous system, you talk about Alfa I and Alfa II Receptors and Blockers, and Beta I and Beta II Receptors and Blockers. Not just generalizations anymore. And as more and more is learned, vertically in that particular area -- the autonomic nervous system, the sympathetic division -- agents now devised that can specifically affect uniquely certain receptors within that nervous system. And they can vary in their types of effect. For example, the first Beta Blocker was Enderol Propranorol. Very long-acting. Water soluble, fat

soluble. Agents have come along now that will work for a few minutes, and then it's done.

CBP: This is really getting off our discussion.

AD: What I'm saying is, that has added to the curriculum in physiology. It's applied into clinical medicine.

CBP: With all these things that are being added, where is the room to add all these things? Have other things been dropped out of the curriculum in medical training to make way for all this new knowledge that's been added?

AD: That's an important point you raised because as more is learned, we're compressing time, and it gets more and more difficult.

CBP: And you're learning more in the same amount of time.

AD: I think it's being taught -- yes. I now and then stop in and I'll listen to a basic scientist discuss. Yes, it's covered. I'd like to see it reviewed again in the clinical years so they can see the correlation between, "Why did I learn that?" and "How do I use it in today's world, diagnostically and therapeutically?"

CBP: What were the highlights of your social experience at PCO in Philadelphia in the 1950s?

AD: Social?

CBP: Yes. When you weren't studying, what were you doing?

AD: That's all we did was study.

CBP: Any baseball at all?

AD: Oh, yes. I played baseball until the night before I started interning.

CBP: Any frosh socials that you remember?

AD: That was spending money. Oh, yes. We had fraternities on campus. We had two dinner dances a year, by Student Council.

CBP: Where were they held?

AD: The last two that I went to -- one was at the Warwick and one was at Medford Lakes. I remember before that, the old Penn Sheraton, it was either a prominent hotel or a convenient place for dinner and dancing. Twice a year the Student Council had a dinner dance.

CBP: During the 1950s, women at PCO were pretty sparse in

your classes.

AD: A lot of nurses.

CBP: Is that where you got the women for your dinner dances?

AD: No, no, no. Well, no. Most of our class were married. In 1952, that incoming class -- a large number of them were married.

CBP: Were you married then?

AD: No. I got married at the end of my internship.

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

AD: At home.

CBP: Where did most of the students live, who weren't local?

AD: Housing as we know it, small apartments, one-bedroom apartments. There were several in the immediate vicinity of 48th Street.

CBP: In the Garden Court neighborhood?

AD: Garden Court was expensive.

CBP: So students weren't living in Garden Court?

AD: The Dorsett Apartments, right across the parking lot, in back. One man had a house on 46th Street.

A few of them lived in West Philadelphia, and lived at home with their wives -- with their families. I guess we were about half and half. A lot of them had children.

CBP: Well, you must have had some older medical students as well because you had the GIs who came back and went to school later, rather than straight after undergraduate education.

AD: A few of the older men -- yes. John Belula, Jim Jemerakis.

CBP: What fraternity were you active in?

AD: Atlas Club first.

CBP: That was a fraternity?

AD: Yes.

CBP: It doesn't have a Greek name?

AD: Atlas is the oldest name for the mythological Atlas, and for the Atlas bone, where the skull sits on the first bone of the spine -- that's the Atlas bone. It's the oldest osteopathic fraternity. I later was also brought into Phi Sigma Gamma. So I belonged to two fraternities on campus.

CBP: Was that uncommon to belong to more than one fraternity?

AD: I don't know if I'm the first one or not. [laughs] But in later years I was brought into Phi Sigma Gamma.

CBP: Could you describe the activities of the fraternities at that time?

AD: They had houses that had several rooms, where a lot of members lived.

CBP: Where were your two fraternities that you belonged to?

AD: There were four of them. Log, ITS, Phi Sig and Atlas were within a few blocks of each other in West Philadelphia, on Spruce Street, for the most part. Nice old homes in there. It was conducive to study. They had the small libraries. They had file systems. They all had active alumni, and they had active educationals two or three times a week in the fraternity houses. A lot of times when they had a special person, it was open to other people to come, as well.

CBP: When did fraternities at PCOM begin to wane, and why?

AD: I have no idea. I don't know.

CBP: From the 1910s through the 1930s, organized athletics was an important part of student life at PCO. For obvious reasons, there appears to have been less emphasis on sports during the war years of the 1940s. Based upon your experience, how would you characterize student athletics in the 1950s and since then?

AD: We had a basketball team. It started out as the West Side Collegians.

CBP: When did that start?

AD: Tom Rowland started that probably in 1951 or 1952. That evolved into Philadelphia College of Osteopathy. There was a league established a couple years later. We used West Philadelphia High School gym initially, and then we moved up and used Dobbins High School gym as our home court. Rutgers of South Jersey, the Philadelphia College of the Bible, Philadelphia Textile -- we played all those schools,

colleges.

CBP: You started off as the West Side Collegians?

AD: We were PCO students. We didn't have a name, but we had a basketball team. [laughs] Dr. Barth donated the money for the uniforms.

CBP: But why did you call yourselves the West Side Collegians instead of a PCO team?

AD: Well, we didn't represent the school yet.

CBP: But Tom Rowland, who was working here at the time --

AD: He was Registrar.

CBP: He helped organize a team that didn't play under the name PCO?

AD: Right. Not yet.

CBP: What did it take to get you to play under the name of PCO?

AD: I don't know. I guess Dr. Barth decided that, and the Board of Trustees. [laughs]

CBP: Were there other sports teams active in the 1950s?

AD: Not organized. No. We had intramurals. Touch football, and things like that. And softball. But no organized leagues like the graduate school

league. Although the nurses did get in the nurses league.

CBP: They had their own basketball team.

AD: Yes. Paul Snoke was their coach.

CBP: Who is Paul Snoke?

AD: He was a classmate of mine. They won that championship. The nurses had a basketball team. They had several good nursing schools in Philadelphia, don't forget.

CBP: There used to be track teams, swimming teams.

AD: Tennis, golf, baseball. Yes. We had individuals that participated in things. We had fellows that were Olympic javelin throwers, gymnasts. People who participated, but not as PCO's organized -- nothing like an organized league. No.

CBP: Please describe any PCOM student traditions you may recall from the 1950s. Was there any deference to upperclassmen? Any freshmen traditions?

AD: Yes, there was a pecking order.

CBP: Could you describe any incidents or anecdotes that you recall about that?

AD: No. [laughs] Not off the top of my head. Oh, boy. The one that just jumped into my head would be -- no, it wouldn't be. [laughs] Better not. But there was a pecking order, and you stood up. You went from the attending, to the resident, to the intern, to the senior, right on down. The level of care in the hospital, I thought, was fantastic for that reason. We had a lot of nurses, and we had a lot of house staff, so that a patient on the third floor might have seven persons attending to his needs for an eight-hour shift. One of the things that patients have complained about when a hospital gets bigger and the halls get longer. As nurses became administrators, and other persons had to step-up to try to fill the nurses' traditional role, and the level of incompetence was frequently reached.

CBP: Back in the 1920s and even in the 1930s, there were certain freshmen traditions, like the men wearing dinks on their heads, and women having to wear green ribbons.

AD: We never had anything like that that I'm aware of.

CBP: Nothing like that survived into the 1950s?

AD: No.

CBP: What was the nature of student-faculty relationships when you were a student in the 1950s, and do you think those relationships have changed in more recent decades?

AD: We addressed most of our lecturers as "Professor." There was always that respect for the teacher. I think it still holds true today. Yes.

CBP: Was there any involvement between students and faculty outside of the classroom, in social situations?

AD: Oh, yes. Well, a few times the faculty participated in the annual Christmas show, as a separate production of their own. A few times. [laughs] Somebody found a picture of -- what you've probably noticed, maybe in some of the yearbooks, where Dr. Nicholas and I were Cinderella during one show. One of my classmates -- our freshmen year what happened -- they had a freshmen orientation. After being in

school for two weeks, on a Saturday night we had our first social because everybody was studying every spare minute you had. We decided to entertain our faculty, so we spoofed our freshmen faculty that we had, for two weeks only. So there was Angus Cathie, Ed Cressman in Histology, Mr. Astwood, who was the helper up in Anatomy -- he was an undertaker by trade, but helped with the bodies up there. So we spoofed all those people, and it went over pretty well. So that year we also had a Christmas show.

CBP: Is that the start of the Christmas show?

AD: I think that they had already had things for the kids. Santa Claus and --

CBP: But as far as the skits?

AD: Yes. And that's the first I can see in any of the yearbooks that showed any, as well. And in those days -- I don't know if you remember Arthur Godfrey. He had a radio show originally, and then he had two singers. Not the McGuire Singers, which were also part of the show, but he had Frank Parker and Marion Marlowe -- a duet. Frank Parker was an old beer

tenor from Broadway, and Marion Marlowe was a pretty, dark-haired girl. And they sang semi-classical. Well, Frank Caruso and I did Frank Parker and Marion Marlowe.

CBP: Have you seen your picture in the exhibit?

AD: Yes. Somebody pointed that out to me in the ribbon-cutting. [laughs] I forgot all about that incident.

CBP: Do you remember the Charity Balls?

AD: I went to one when I was a senior. But I remember my mother and father preparing and getting dressed-up to go to those when I was a little kid. I remember the year -- the excitement when Paul Whiteman was the band. Oh, gee. Yes. They were big times, in those days. I remember the Women's Auxiliary as a kid. That was active.

CBP: What do you remember about it?

AD: We'd meet at Dr. Eaton's house or Clarence Baldwin's, and they'd have clambakes. Somebody would bring a guitar and a banjo. Harry Hessdorfer and my father, and everybody would be singing.

George Guest, Chief of Psychiatry showing us a postcard that he got from another member of the psychiatry staff who was on vacation that said, "Dear George, having a wonderful time. Wish you were here to tell me why." [laughs]

CBP: [laughs]

AD: There was a lot of camaraderie.

CBP: Do you think that still exists today?

AD: Well, you don't get the opportunity to be with the faculty as much, I don't think.

CBP: Why is that?

AD: I don't know. Some of the portraits on the library -- some years ago we reinstituted sort of a dinner dance thing. For some reason we dropped the charity ball option, probably in the mid-1950s.

CBP: I'm not sure.

AD: I think the last one might have been at the new Penn Sheraton Hotel on Presidential Boulevard, which is Kennedy Boulevard now. That was a brand new place, in that big ballroom. I think that was the last one. We tried to reinstitute it as a staff faculty

function when I was Program Chairman of the staff, and that's where we got that big portrait of Angus Cathie. Each year we honored somebody from the staff faculty who is a big -- the way our bylaws read, in order to be a member of our staff, you had to qualify to be a member of the faculty. And the hospital was part of the College, so when we reestablished our dance, we did it through the faculty staff, so we honored somebody from the faculty at our staff faculty dinner dances. We went to Angus Cathie, Jake Leuzinger, P.T. Lloyd, William F. Daiber, and Joseph Py, those five consecutive years. And I think that was stopped.

CBP: When did that start? Which were those five consecutive years?

AD: In the 1960s.

[end of side one]

CBP: Are there any other student faculty events that you'd like to comment on?

AD: One that has been appealing and is looked forward to by the house staff and the faculty is the so-called Rest & Rehabilitation Day that has taken place in June of each year at the Eagle Lodge. The sport competition is fun. It gives an opportunity for faculty, staff and house staff to mix socially, and on a different level. The problem is with getting the students into those same situations, although when we came through school, I'll never forget the Chief of Pathology had a picnic for us as a graduating class.

CBP: Who was that?

AD: Ruth Waddel Cathie. She had a farm up in Schwenksville. That was our second date -- my wife and I. So I remember that. But often, somebody from the faculty would have a small get-together for members of the classes, and a lot of times it happened through the fraternity activities, though, too. I guess there was more social life than I described because I wasn't on campus, so-to-speak, where a lot of the men and their wives were either

in fraternity houses or in housing right in the neighborhood, and would visit each other. It was a big thing to go to movies.

CBP: When did cardiology become a specialty?

AD: It started around 1971, while we were organizing the American College of Osteopathic Internists into the -- I think -- ten subspecialties, at that time. I happened to be on the Board of Directors and was becoming President-Elect of the College when we were making in-roads into those areas.

CBP: Prior to that, was it part of medicine -- internal medicine?

AD: Yes, in general. It was part of medicine. Practically every cardiologist was an internist first.

CBP: Did the specialty of cardiology develop simultaneously in the osteopathic and allopathic schools of medicine?

AD: It paralleled somewhat. The American College of Cardiology, though, had already been established.

CBP: Prior to the osteopathic profession establishing

cardiology as a specialty?

AD: Yes. As a subspecialty.

CBP: What role, if any, did PCOM play in the development of cardiology as a specialty?

AD: Well, we helped to organize the bylaws of the specialty, the requirements and qualifications needed to become board eligible in the subspecialty, and to finally attain certification in the specialty. Those are examinations and training programs now established all over the country.

CBP: Why was there this need, in 1971, to set-up all these subspecialties?

AD: The course curricula was expanding so much it exploded. In all the specialties -- so that you had more and more of a need for specialties. Not necessarily more and more specialists, but the need to train physicians in the specialties, so that they have an awareness of it. I think the student, at the end of his four years of basic medicine in school, should be a super physician because he's had the opportunity of learning and hearing instruction

at all of these super-specialty levels. Now, you might not be a cardiothoracic bypass surgeon, or take sections of the heart out -- infarctectomies -- but he knows that procedure is available for his patient if it's necessary, and he knows how to access it. How to plug-in and where he can get it done by qualified people. He knows that studies are available. He may not do the study himself, but he has qualified people that are able to provide those studies and those diagnostic procedures. It's the awareness of it. It's like a good library. You may not know it, but you know how to get to it in a library.

CBP: Could you describe the history of PCOM's Department of Medicine and its Division of Cardiology, beginning with the first Chairman, William Daiber, D.O.?

AD: First Chairman of Medicine was Ralph L. Fisher.

CBP: But Daiber being the first Chairman of Cardiology -- the Division.

AD: Dr. Daiber was the Second Chairman of Medicine. He

was the first to chair the Division of Cardiology at the same time, practically. He developed it, although everybody did cardiology as well as everything else.

CBP: How did the practice and teaching of cardiology at PCOM change once there was a distinct Division of Cardiology headed by Dr. Daiber?

AD: Well, we were able to access other educational capabilities like the first teaching cardioscope in the Delaware Valley. This was an apparatus where you can monitor the patients' cardiogram, and through an electronic stethoscope set-up, could study heart sounds and adventitious sounds -- abnormal sounds -- and murmurs, and visually see those patterns at the same time. So you had the opportunity to utilize that as almost like a metronome -- the cadences. The different rhythms that may be associated with those various types of cardiac rhythms. We had two of those, in fact. One at 48th Street and one at 20th Street. They were made by Cambridge Instruments. Ours was better than

anything they had at Hahnemann at the time. Using that equipment, there was a series of tapes produced by Columbia Records, by a Dr. Butterworth, "Heart, Sounds and Murmurs." These were teaching tapes. Then we could make individual loops of patients and play them back and study them.

CBP: This is all since the time that cardiology became its own division -- its own specialty?

AD: As that did, what happened -- the American Heart Association provided funds for all teaching centers to assist in providing certain equipment for teaching students and young physicians -- cardiovascular diagnosis. That goes on today. These things are still being involved and on CD Roms now. Fantastic electronic equipment. Mimic and reproduce various sounds that come from the heart.

CBP: Dr. Daiber chaired Cardiology from 1971 to 1990. Is that correct?

AD: No. 1990? No.

CBP: You started in 1990?

AD: No, I was Chairman before and then I stopped, and

then I was Chairman again.

CBP: I'm trying to get the chronology of who chaired when.

AD: Dr. Daiber was the first Chair, and I was the second. Dominic Pisano was the third and then Dominic left, and Michael Kirschbaum became Chairman. Then Michael left and I became Chairman again.

CBP: Why did you step down as Chairman for that time period?

AD: Well, actually, they wanted a whole-time person. I was not whole-time. There was a desire on the part of the administration to have whole-time persons as Chairmen of Departments and Divisions.

CBP: Could you give me some rough timeframe for this?

AD: I have it written down on my CD. I don't have it memorized. I chaired from -- when we came over here -- that was 1967. I chaired from, I guess, 1969 or 1970 through most of the 1970s.

CBP: That confuses me because before you had said that the Division wasn't even formed until 1971, and that

Daiber was the first.

AD: No, no, no. As a subspecialty. We had Divisions of Cardiology, we had Divisions of Metabolic Disease, we had Divisions of Respiratory Disease. But they were not subspecialties yet in our profession.

CBP: Not recognized subspecialties?

AD: We had no yardstick for credentialling or examining yet. So when we started in 1971, the three were cardiology, gastroenterology and hematology/ oncology.

CBP: But internally, then, you had a Division of Cardiology prior to it being officially established as a subspecialty?

AD: Before it was even established. For example, in medicine, for the didactic lecture series in medicine, you had cardiology, pulmonary nephrology, disease of metabolism, hematology, oncology, nephrology, gastroenterology, and I can remember all the rheumatoid diseases. Neurology was not a part of it then. Dermatology is part of it, but it wasn't included then. And allergy and immunology.

They were the ten.

CBP: Then when did this internal Division of Cardiology have a distinct leadership apart from an overall Department of Medicine?

AD: That would be sometime in the 1970s, but I can't give you the exact date.

CBP: But you chaired Cardiology prior to the 1970s.

AD: I was in charge of CCU and ICU and Cardiology here, after Dr. Daiber had his stroke.

CBP: Right. But Daiber started the Division of Cardiology even before you.

AD: Yes. He started it.

CBP: So we're talking about at least the 1960s.

AD: Oh, yes. Oh, yes.

CBP: Okay. That's what I'm trying to clarify.

AD: That would go back into the 1950s.

CBP: That's what I wanted to know. When was there an organization in PCOM that was a Division of Cardiology, independent of what happens in the National Osteopathic --

AD: But there was no separate Division of Cardiology,

per se. It was part of medicine.

CBP: Was it called the Division of Cardiology?

AD: We had a heart station, we had a heart clinic. But it was not called Division of Cardiology, per se.

CBP: Then what was the entity that William Dabier headed-up and that you followed?

AD: He was Chairman of Medicine and headed the Section of Cardiology.

CBP: And then you followed him?

AD: I followed him.

CBP: As the Section Head of Cardiology, or --

AD: Section Head of Cardiology. Not as Chairman of Medicine.

CBP: Just Section Head of Cardiology?

AD: Right.

CBP: And then who followed you?

AD: But I was Vice Chairman of Medicine because I was Section Head of Cardiology.

CBP: I just want to stick with the cardiology genealogy now. [laughs] After you were Section Head of Cardiology, what happened next?

AD: Dom Pisano was brought in as Chairman of the Division of Cardiology.

CBP: So by then you were at least in 1971, and you had the Division of Cardiology?

AD: Yes. I can tell you what year that was, in fact, because he was part of the reunion class, and I was trying to get him to speak. He was in the Class of 1972. And that's the 25th Reunion Class. He interned in 1973, he was a resident in 1974/1975, and a fellow in 1976/1977. So he came in late. And when he finished his residency, I had asked him to come in with me, and he chose to go whole-time and become Section Chief of Cardiology. So that's got to be 1977 or 1978.

CBP: At what point is there a transition from a Section Chief of Cardiology to a Chairman of a Division of Cardiology?

AD: That has to be around the same time.

CBP: Late 1970s, are you talking about?

AD: Sometime in the 1970s. Yes. There were a lot of things going on there that confused the issue

because, for example, one of the nearby hospitals was losing its Chief of Medicine and Cardiology, and I was asked to cover that hospital, so I became Chairman of Medicine, Chairman of Cardiology and Chief of ICU/CCU, while I was Vice Chairman here and Director of Cardiology here. [laughs]

CBP: What was that other hospital?

AD: Tri-County.

CBP: Is that the one that is in Norristown now?

AD: No, that's Suburban.

CBP: Where is Tri-County?

AD: Sproul Road, Springfield. Right in those three counties. Who owns it now? Fitzgerald Mercy or one of them.

CBP: What kind of training had you received in cardiology as a medical student at PCO in the 1950s?

AD: State-of-the-art. Excellent training in cardiology. We had forty-four hours of cardiology in the curriculum.

CBP: Was it lecture, clinic? How would you describe it?

AD: Oh, you mean not even counting the clinic -- it was

lecture. Forty-four hours of didactic lecturing, plus the specialty clinics, plus what you got on the floors.

CBP: What kind of training in cardiology do medical students at PCOM receive today?

AD: They get their first exposure as freshmen, as a correlation of anatomy, physiology and pathology. We see them again in the third year for four-week rotations, where they have daily lectures and clinical experiences five days a week. They have an entrance exam to see where they are, and they have an exit exam to see where they went, and these were all graded and reported. We tried to upgrade it each year with each tour. So that we do get all of the students. And then in the fourth year, we have several come back on electives. And then we have some from other schools come in, too.

CBP: Is there a role for osteopathic manipulative therapy in the teaching of cardiology?

AD: Oh, yes. In the differential diagnosis of chest pain or thoracic wall pain, there's a lot of

overlapping between muscular skeletal problems and cardiovascular causes for chest pain, as well as a lot of other neurologic, traumatic, rheumatologic, and other causes for the same -- esophagial (?), upper G.I., pulmonary. A lot of causes for chest pain. And a lot of things that are thought to be cardiac are actually osteopathic. But it's not only there. It's also utilized in cardiac arythmias. Not only in the differential diagnosis of chest discomfort or pain, but in electrical disturbances of the heart.

CBP: As a practitioner of cardiology, do you use OMT?

AD: Certainly.

CBP: What kind of training did you receive after your four years at PCOM?

AD: In school I had an excellent internship and residency and then fellowship.

CBP: All at the PCO hospital?

AD: PCO and Hahnemann. In those days, though, I had to make my rounds and get done so I could get down to Hahnemann before eight o'clock in the morning.

CBP: Could you explain how you had a relationship with Hahnemann as a D.O.?

AD: Actually, I was introduced to Charles Baily and Harry Goldberg and William Wykoff as a resident, and through Dr. Arthur Flack and William Daiber -- well, Hahnemann was the heart center of the world then, and I was fortunate enough to be able to be exposed to their fantastic program down there.

CBP: I want to interrupt with one question. Were you doing a strictly cardiology residency?

AD: No, I was doing a general medical residency, and stressing cardiology as it was evolving now in the allopathic field.

CBP: And you went to Hahnemann to get your cardiology training?

AD: Yes. I got a lot of training in school here, with the members of the Department, and with Wilbur Lutz and Victor Fisher.

CBP: In cardiology?

AD: Yes. In all of medicine, but especially in cardiology. And then down there with the fantastic

people that they had.

CBP: Give me some timeframe. This is when? 1960?

AD: Through 1960. From 1956 to 1960.

CBP: Okay. At that point, Frederick Barth was in charge of the institution here, and the overall policy was not to be interacting with allopathic schools.

AD: Not at all.

CBP: Well, that's what I've been hearing from some discussions.

AD: No.

CBP: That it was more isolationist at that time.

AD: No, no, no. We're talking about the graduate level, professional training.

CBP: Okay. Maybe that's where I need some clarification.

AD: Oh, yes.

CBP: So you were encouraged to get into the allopathic environment?

AD: We were encouraged to learn. Absolutely. There was no problem. In fact, some of those men I still know today -- I know them very well. One of my mentors was one of my sponsors for the American College of

Cardiology. That's how I got my fellowship.

CBP: Who was that?

AD: Harry Goldberg.

CBP: How did you juggle your time between the PCO hospital and Hahnemann?

AD: In those days, I had to make rounds in my assigned hospital, whether it was 48th Street or 20th Street. Get my rounds done, report to the person that's covering me, and I would shoot down and park in the back alley at Hahnemann. There was no parking lot across the street yet. You went through all the cath procedures for that day, and reviewed all the cases with Dr. Goldberg or Burt_____, diagnostically, and then some rounding on the floor. Whenever that day was done, we finished and came back to where you were assigned and checked your patients at the hospital again.

CBP: Were you having a call schedule at both places?

AD: I wasn't on call. No. If I had a primary service at 48th Street, Dr. Daiber would say, you finish your rounds, you report to the guy that's covering,

and then you go. Then you come back, you report in again, and he reports to you. Because most of the time we were on two out of three nights.

CBP: So you had call at 48th Street but not at Hahnemann? Is that correct?

AD: Yes.

CBP: How were you received at Hahnemann by the M.D. residents?

AD: They offered their services to cover our hospital because they wanted more work to make a couple dollars. No problem.

CBP: No prejudicial attitudes toward you being a D.O.?

AD: No, none at all. By the way, that led to our being able to rotate our students and our interns through Deborah, because Harry Goldberg became Director of Deborah while he was there and while he was Chief of Cardiology at Einstein. We developed a wonderful relationship in our people. To this day, our people are still some of their major staff.

CBP: Could you please describe the origin of the fellowship and residency programs in cardiology at

PCOM?

AD: Once the bylaws of the subsection were established and the requirements listed, we opened up to fellowship applications.

CBP: Are you talking about the early 1970s now?

AD: About then. The first applicant was James Dale. He was our first Fellow in Cardiology.

CBP: When was that? Do you know?

AD: He practices down in Virginia. Luray, Virginia. That's got to be fifteen years, at least, ago. I'll have to check the dates again.

CBP: He was your first fellow or resident?

AD: First fellow in cardiology.

CBP: Did the fellowship program come before the residency program?

AD: We're using similar names. PGY I, PGY II, PGY III, PGY IV and PGY V. Post Graduate Year -- first year is internship, second year is residency. In order to be certified in cardiology, you had to take your internship, two years of general medicine, two years of cardiology. If you didn't want to do invasive or

cath. If you wanted to do electro-physiologic studies, it takes a third -- another year. So it's internship, two years general medicine, three years of cardiology. To take a general medical examination with stress and cardiology, but doesn't qualify you as a specialist in cardiology, you could take two plus one. To take cardiology, you had to take two plus two or two plus three. So in order to be boarded in cardiology, you have to also be first boarded in medicine. In order to be boarded in a subspecialty, you have to be boarded in a primary specialty.

CBP: In that description of PGY I, II, III, IV, V, where does 'fellow' fit in?

AD: Fellow begins in internship PGY IV.

CBP: So when you're beginning to really specialize in the cardiology part of your training?

AD: No. I should qualify that. Now there's fast track.

CBP: First tell me how it was! [laughs]

AD: [laughs] How it was originally? After internship, two year residency, one year fellowship.

CBP: And that fellowship is when you were really focusing on cardiology?

AD: Right. That was changed. Two year residency, two year fellowship.

CBP: When was it changed?

AD: Oh, boy. I don't know the exact date. I helped to change it. If you're going into EP -- electrophysiology -- you need a third year of fellowship. So it was two years of medicine -- general medicine -- by the way, which included cardiology, as well as all the other subspecialties on your services. Now it goes two plus three for EP, but a lot of people don't go into EP. You want to get done and get practicing. So they get double boarded. You go into EP and you get triple boarded. So you're talking general medicine, cardiology, electrophysiology.

CBP: Was PCOM the first osteopathic college to offer cardiology residency?

AD: No. In cardiology, you're asking, specifically?

CBP: Yes.

AD: The first medical residency was established by Mort Terry.

CBP: Here, in 1945?

AD: Yes. In fact, that's a great story you have to talk to him about.

CBP: Yes. He's on my list of people to interview.

AD: I wouldn't do it justice.

CBP: I'll talk to him.

AD: That was with Ralph L. Fisher, Chief of Medicine. There's Jim Dale, Serge Riley, Alan Keogh, Ken Smith, Don Fornace, John Fornace, Wayne Arnold, Joe Kenny, Peter Frechie, Eve Assesso.

CBP: Who are all these people you're naming?

AD: People that came through our fellowship program in cardiology.

CBP: You're using fellowship almost the same as residency?

AD: Yes.

CBP: What have been your greatest accomplishments as a practitioner and as a teacher?

AD: Accomplishments?

CBP: Yes. Achievements. If you had to toot your own horn right now.

AD: Well, my greatest accomplishment was last January. I was overwhelmed to say the least. Receiving the O.J. Snyder Memorial.

CBP: That was a recognition for your achievement.

AD: Yes.

CBP: What do you think is your most significant achievement such that you got that award?

AD: Having survived. Having had the opportunity to go to school and learn and teach. They're the thrills that I look forward to every week. Having patients that were happy and physicians that were satisfied with the service. Being available when called upon, and knowing a heck of a lot of good people. You're only as good as the people around you.

CBP: Which other cardiologists at PCOM warrant recognition for their contributions as teachers and/or practitioners?

AD: All of them. Absolutely. Yes.

CBP: Have there been any significant research efforts in

cardiology at PCOM?

AD: Well, the published research in cardiology was in the British Medical Journal -- two issues of it -- coronary heart disease.

CBP: Was this your research?

AD: It was combined. Mike Kirschbaum was the Chair of the Division when it was done, and Dominic DeBias in Pharmaco-Physiology and Dr. Nicholas, Dr. Heilig, Dr. Nicholas Nicholas -- the father and son -- and Walter Ehrenfeuchler. They all participated in that. That was one of the fringes because I knew what was going on with patients.

CBP: If you were preparing a time capsule, and this time capsule is intended to preserve the memory of PCOM, what events of the last twenty-five years would you highlight? So we're looking back to around the mid-1970s.

AD: Just the last twenty-five years?

CBP: Yes.

AD: Moving out to City Avenue, the expansion of the College facility, ongoing. You have to emphasize

that. The expansion of the faculty. The expansion of the student body. The responsiveness of federal and state agencies to our graduates. Our people are all over the place now. Federal, state, public health, Armed Forces. And it still maintains a uniqueness. That's the osteopathic philosophy and approach, as well as manipulative therapy where it's appropriate.

CBP: What have been PCOM's greatest shortfalls?

AD: Money.

CBP: You're not the first one to say that.

AD: Over the years -- if we had had funding available -- because of the dynamism of the individuals at the times -- oh, boy. They were giants. They were giants in this area that had the audacity to buck the establishment. And they did it because they were good people, and they were pretty convinced that what they were doing was right, and they went ahead and did it.

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

the 21st century?

AD: Don't forget who you are.

CBP: Could you explain that?

AD: Yes. You want to maintain your uniqueness or you want to merge. I think when people come to the school they make a commitment, to maintain committed for patient service and patient care. That's the primary commitment. How it's going to respond in the era of changing medical care -- I don't know how it's going to change it because people are not sure how it's going to change it. But I hope the quality of care isn't affected.

CBP: Do you have any concerns about osteopathic physicians practicing as osteopaths?

AD: No, they can't get away from the fact that they are.

CBP: But are they going to practice as osteopaths? Are they going to use OMT?

AD: For some individuals, I guess, it's harder for them to practice as osteopaths because it's more time-consuming. You have to lay on the hands. If a person is more bean counter-oriented, then he has to

accomplish so much in a given span of time. One bean from one minute, etc. And at the end of sixty minutes, there better be sixty-plus beans. Otherwise you've failed. Well, I don't know. Sometimes you have to use twice as much time for one patient as another. And this is one of the things that's being addressed by the federal agencies that are providing stipends for aged America. They want to pay you for your time, as well. So spend the time with the patients. That's what they're trying to encourage, and I think it's good.

CBP: I don't have anymore prepared questions for you. Is there anything else that you would like to add to this interview?

AD: No, it sounds great. I think you're doing a great job, Carol. If I can help you with anything else, let me know.

CBP: Thank you.

End of Interview

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