1996

Henry D'Alonzo Oral History

Philadelphia College of Osteopathic Medicine

INTERVIEW WITH HENRY D'ALONZO, D.O. (CLASS OF 1951)
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
June 6, 1996

PERLOFF: Dr. D'Alonzo, please state your full name and date of birth.

D'ALONZO:

CBP: Please tell me where you were raised, and where you currently reside.

HD:

CBP: What is your address, please?

HD:

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

HD: My father was an osteopathic physician.

CBP: What was your father's name?

HD: H. Enrico D'Alonzo. He taught at PCOM in the clinics, and he was a general practitioner. He practiced in his home, where I lived, and I was

introduced every day of my life to medicine. If I needed my father, I just knocked on his door -- his office door -- and my mother was in the house doing the chores. He always lived with us and practiced with us. I used to make house calls with my father. I remember at the age of four or five, having to help him with a little girl who was afraid. He had to take some blood from her for tests, and she was afraid, and he used me to calm her.

CBP: How did you do that?

HD: For some reason it just came natural to me because I was a pretty reliable kid. In those days I used to do things like take care of the heater, which was a gas stove. I took care of that. Make sure the house was warm. I answered the phone when my father and mother weren't home, took messages, went on house calls with him. I can remember a very interesting thing one time. I was just a little kid and a man called and said he wanted my father to see his mother, who was in her nineties. I asked him what the problem was. That's how open I was,

because that's what my father would instruct me to do. He said when she walked up a flight of stairs, she got out of breath. So I said to him, "Well, I get out of breath when I go up a flight of stairs." I remember saying that to my father. He thought that was an interesting comment. [laughs] He said, "You're probably right. She's in pretty good health, but we'll have to look into it to make sure." But that type of thing went on. My mother many times, later on, when I started the practice, right out of the same home -- she would leave messages for me. "A patient called. Her son's got a rash. It sounds like Measles." She'd make the diagnosis for me. [laughs] When I first started I did some general practice work for my father, being that was trained to be a surgeon. That's how we started. I did some general practice.

CBP: I understand there are even more D'Alonzos who are part of this medical family.

HD: Yes.

CBP: Can you give me your family medical tree?

HD: Well, my brother is Dr. Albert D'Alonzo, who is Chief of Cardiology. He just won the O.J. Snyder Medal this past year. Al is my younger brother. I taught him all he knows -- or all he knew. [laughs] All I knew. [laughs] My wife is a D.O. She was a student. I met her as a student when she was a sophomore. I was lecturing to her. I married her as an intern in 1966. I was almost forty years old at the time, and she was much younger. My mother was always in the women's auxiliary. She ran a lot of parties and spaghetti dinners and things like that, to raise money for PCOM years ago. I guess that's what you want to hear.

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

HD: I went to Temple University for three years. However, if I got a couple more credits, I would have had a degree. But I was so anxious to start medical school that I started in 1947 at PCOM. Although I was admitted to several medical schools out of town, I elected to stay here at PCOM.

CBP: Are you talking about osteopathic medical schools?

HD: No, medical schools. AMA schools, before that time.

CBP: What made you apply to AMA schools if you had this strong osteopathic ?

HD: Well, for example, at Temple University, I was told I could get in there with no problem because my grades were so good, and my physics teacher liked me over there. I got straight A's in physics and so forth. However, when the time came, I didn't get into Temple. They were taking a lot of foreign students and people who had been in the Service. I had never been in the Service. At Hahnemann -- my father originally went to Hahnemann before he went to PCOM, so I applied at Hahnemann. And then a cousin of mine was in the State Department. For example, in Washington, I applied to Washington University down there, and I was accepted down there. But I decided to go to PCOM. We had some problems in those days. My father is an old pioneer in this stuff. My father was sued in 1927 for practicing medicine without a license. In 1928 he

was sued for practicing surgery without a license. My father was a D.O., and they were both thrown out of court, so I consider my father a pioneer. We practice osteopathy as taught, from that time on, as a result of those two decisions back in the late 1920s.

CBP: At what point were the osteopaths licensed to practice surgery?

HD: I don't know the exact year, but they were always licensed to practice surgery. But we had to take a special board. We took a board in surgery, which I took, myself, when I finished my residency because before that you got a D.O., which is a Doctor of Osteopathy, and in order to get the surgical license -- for example, we had to do three hundred and fifty cases in two years, and hand in a bunch of documents, and then pass the state boards, which I passed. But just a few years after that -- I passed in 1954 -- it must have been the early 1960s when all D.O.s were licensed to practice surgery on graduating from PCOM, or any osteopathic school in

the early 1960s. You didn't have to take the special board. In other words, if you wanted to be a practicing surgeon -- do major surgery -- you had to take a surgical board before the early 1960s.

CBP: Before the early 1960s?

HD: Yes. Osteopathy, which is defined as medicine, and surgery in the State of Pennsylvania.

CBP: But getting back to your father's time, when he was sued for practicing without a license, was there a surgical licensing requirement in the 1920s?

HD: No, I doubt it. I mean, even the M.D.s didn't have those things. We always had surgery. For example, I was operated at PCO five times in 1934 by Dr. Street. Now, Dr. Street -- as far as the osteopathic surgeons were concerned -- he was number three. I know the numbers because --

CBP: Who was one and two?

HD: No, I think Street was number two. Number one was Dave Pennock. Dave Pennock was an M.D. D.O. He was the first surgeon we had. As far as I know, we always practiced surgery. It was just the

licensing. It gets into complications because there was a problem. Our original incorporation was in New Jersey. I'm getting into complications now. But since New Jersey never had a medical school, our surgical license and so forth to practice surgery at the hospital, came through Pennsylvania. And that wasn't squared up until the 1950s, so that we incorporated everything in Pennsylvania. But originally, since that time, of course, New Jersey had schools of medicine and osteopathy, but they didn't have them in those days. They were one of thee few states that didn't have licensing or medical schools or osteopathic schools.

CBP: What were the highlights of your educational experience at PCOM in the late 1940s and early 1950s?

HD: The man that sticks out in my mind was Dr. Angus Cathie. He was the Professor of Anatomy, and he really impressed me because he was a strict disciplinarian, he was a great teacher. His personality had a lot to be desired, but he taught

me a lot. In fact, I got a rate of 100 in anatomy from him, so he's really prominent in my mind. Dr. Senior in Chemistry, Dr. Baldwin in Pharmacology and Physiology. We had great diagnosticians in the Department of Medicine. For example, Victor Fisher was Chief of Medicine. By that time, Dr. Eaton was Chief of Surgery. Very prominent in my background. A great guy, he died in 1962 at the age of fifty-two, which was a great loss, because he was Mr. Osteopathy, as far as PCO was concerned. Chief of Staff, Chief of Surgery, Chairman of the Board of Surgery, so forth and so on. He had all the titles, and he was a great guy, and one of my favorite surgeons. And then there came other people, such as Arthur Flack, which I had most of my training with. But I could go on and on. Dr. Herman Kohn was the first surgeon that I met. You say how long have we been doing surgery? Well, my father graduated in 1927. Dr. Herman Kohn -- we were practicing surgery. As far as I know, osteopaths were practicing surgery from the beginning of time, but

it just was the licensing in certain states that was difficult sometimes, because the M.D.s tried to hold us down in that area. Herman Kohn was in my father's class, and he was the first surgeon I ever met. I met him one time at the hospital. I used to go to the hospital with my father, I made house calls with my father. I met Herman Kohn one time in the parking lot outside the hospital on one of these visits to PCOM when it was at 48th and Spruce. Herman Kohn was one of my teachers and one of the men I respected, but we had all great teachers, and the great part about it was that these guys weren't generally paid. Maybe one or two of them were paid. All the other teaching was free.

CBP: When did the teachers start to get paid?

HD: Well, as I say, Dr. Cathie was probably the first to get paid, and there might have been one or two other guys got paid, like Dr. Senior in Chemistry. When did they start to get paid?

CBP: being a volunteer.

HD: Well, I'm not that old. [laughs] For example, I

taught all my life at PCO and didn't get paid. Near the end, they were giving me a lecture, which I taught for nothing, for over forty years. I started as a clinical assistant and became assistant, and demonstrator, instructor, associate, assistant professor, clinical professor, full professor, and now professor emeritus. I went through the line there. I never got paid, except in the last few years, during Dr. Wiseley's time, who was Chief of Surgery before Dr. Pedano. During that time everybody got paid when they lectured in the lecture hall, but we didn't get paid otherwise.

CBP: About what time period was that?

HD: You're talking about the 1980s. Most of the people before that -- it was a graduate thing. For example, the basic science instructors were getting paid quite early. Most of the clinical men didn't get paid.

CBP: Why was there a distinction between the basic science teachers being paid and the clinical --?

HD: You're going to get me into politics now. When the

politics got into this thing, you had to be in a political appointment. Administration made the appointments. For example, we didn't elect the Chairman of the Department of Surgery, nor do I think the Chairman to this day are elected by the staff. They're elected by the administration, and you understand that's political. You may be getting me in a tough area here, with the administration. But if you want the truth, then you're going to get the truth from me. I never got paid, so I wasn't in for the politics. My brother was into the politics. He's gotten paid a certain stipend for years, and I'm talking about Dr. Albert. But as I say, the only payment I used to get was for -- they would give me a per hour of lectures, so you might give six lectures and you might get a stipend. I remember in the beginning there was some ridiculous amount like twenty-five dollars for the hour, but you wouldn't get paid for any of your operating room time, teaching students, and so forth. We never got paid. But now, since the money's been coming from

the state, they started to put people on salary, and as I say, most of those are political appointments.

CBP: When did your clinical training begin as a medical student?

HD: In my third year. In our third year we were responsible for class lectures, and even though the fact we were in clinics one-third of the time and in the hospital one-third of the time. You couldn't attend all lectures, but you were responsible for those courses. That's when we started taking notes, so that you had a set of notes to call back on when you attended the lectures. You could hardly attend the lecture if you were in another hospital away from the college.

CBP: What courses were you taking while you were doing the clinical training?

HD: Most of those courses had to do with clinical medicine. In opthamology and EMT. We covered the whole gamut.

CBP: Was there a note-taking service?

HD: No, no. Students did it themselves.

CBP: You would help each other out?

HD: Yes. We actually mimeographed our own notes. That's what we had to do. We had a team. We'd take turns. When you were in the lectures, certain people were designated note takers. The best ones -- they would compile that, put them up, and pass them out to everybody. So that meant later, the professors themselves -- I did it myself. I made out lecture outlines and so forth, .

CBP: How was the clinical part of the curriculum organized, as far as what you did in your third year, what you did in your fourth year, how your time was spent?

HD: Oh, there was definite time allotment. In your third and fourth year you had to go all departments -- surgery, medicine, obstetrics, gynecology, urology. You spent a certain amount of time in each one of those. Sometimes you would get that in an outlying hospital, rather than a home hospital because of the numbers.

CBP: Did you work in the clinic and the hospital?

HD: Oh, yes.

CBP: Third years and fourth year, or was clinical one year and hospital another?

HD: Third year and fourth year -- both. But you were assigned -- I think, as I recall, one-third of the time went to the hospital, and one-third went to clinic. It probably was half-and-half. One-half hospital and one-half clinic, but then you were liable for the lectures, as I say, which I elected most of the time not to attend because I thought I was learning a lot more in the clinical areas there.

CBP: Please share your recollections of working in the 48th Street Clinic as a medical student.

HD: You've got to have a visualization, and people who were never there will never know what PCOM and 48th Street looked like. But the original building was supposed to be an apartment house, and we took it over and the people who were building that place lost money. We took the place over as a medical school and a hospital.

CBP: It wasn't strictly designed to be a hospital?

HD: It was designed to be an apartment house in West Philadelphia, and the people building it probably lost money, and we bought it very cheaply. In fact, the doctors -- the private physicians themselves -- all put up money and bought the place.

CBP: How far under construction was it when it was built?

HD: I'm not that old! I was a patient there in 1934. That's all I could tell you. The hospital and the college were there for a good many years before that. In 1934 I was operated on there five times. A whole summer I spent at PCO.

CBP: The ground-breaking and the whole construction was not done for PCOM?

HD: As I say, it started out -- the plans were this was going to be an apartment house, and I can't tell you how far built the apartment house was, but at some point, the architecture changed the plan over. The reason I tell you about this is because the clinics were in a basement floor, underneath the couch. So they were part of the college. The college was four stories and the basement. The clinics were in the

basement, and you had a booth, and all the students were assigned to certain booths and certain groups of patients. You had all kinds of supervisors, general practitioners, professors, specialists who were working down there, and any time you had a problem with a case, they were right there to teach you and inform you and instruct you. It was very thorough. We were always anxious to learn more and more, of course. One of the things that disappointed me in the beginning was we had a lot of chronic patients, which it turns out, that's what general practitioners have. And since I've been raised with a D.O. all my life, I knew what that was all about. I didn't want to know about that -- I wanted to know the extra-special stuff. I think it was great because we all went through that period when we took care of general practice patients, even though we became surgeons or whatever we did later on. It was hard work.

CBP: Did you teach patients one-on-one, or were a group of students assigned to --?

HD: One-on-one. You more or less ran a private practice down there, while you were there. And they were open all day long, I believe -- the clinic. We had a lot of patients who just came -- all day long coming in there.

CBP: While the school and hospital were located at 48th and Spruce, the 19th and Spring Garden facility was used as a pediatric clinic run by Dr. Wagner. Do you recall this clinic?

HD: Leo Wagner? He was Chief of Pediatrics, of course. We were at Spring Garden street originally. That was our college originally.

CBP: Right. And that's what they did with the building when you moved out.

HD: I imagine, so you're telling me something I'm not too sure. Not while I was a student.

CBP: So while you were a student the pediatric clinic was no longer in operation at 19th and Spring Garden?

HD: Not that I know of. I never heard of it. I just thought we left that place, but it sounds very plausible that they used it. Yes.

CBP: What other clinics did you train in while a PCOM student? Off site, not at 48th Street?

HD: Metropolitan Hospital.

CBP: Where was that located?

HD: There was a street north of Spring Garden Street. They had a hospital down there. In those two years I spent a lot of time in Metropolitan Hospital, especially in surgery.

CBP: Was that an osteopathic hospital?

HD: Yes.

CBP: Strictly osteopath?

HD: Yes. One hundred percent. The interesting part about that hospital -- they had no elevator, so we used to carry patients from floor-to-floor on stretchers. Surgery, I think, was on the third floor, so the patients we'd bring up. In fact, as a student, that was one of the things you did. You followed your patients. Following your patients meant you took them to the operating room. We attended all the special clinics. We also had assignments to special clinics. Besides having

general practice, you had assignments to the OB/GYN clinic, you had assignments to the medical clinic. But the point was you followed your patient wherever they went. In other words, if your patient wanted to be consoled and you were practicing, somebody would call you and say, "Your patient is here," and you'd go down and you'd run around. You really had to run to learn, but we worked hard.

CBP: Do you recall an obstetrics clinic at 3rd and Lehigh?

HD: That's probably later on, isn't it? Because we have clinics all over the place now.

CBP: Yes, but there were other clinics earlier.

HD: 34rd and Lehigh obstetrics clinic? 3rd and Lehigh is right next to the Episcopal Hospital, practically. I can't say I remember that. What year was that, do you know?

CBP: I know it was there in the 1940s.

HD: Oh, that's like I say -- that was later on. I thought you were talking earlier. We had clinics all over the place.

CBP: Where else do you remember having clinics?

HD: Where I went to?

CBP: Yes.

HD: Well, another hospital we went to used to be called River View Osteopathic.

CBP: Where was that?

HD: It was in Norristown. It's now Suburban General. We used to go there, too. We gradually, over the years, went to more and more clinics and hospitals.

CBP: How did you physically get to all these different ?

HD: Oh, you got there yourself.

CBP: By public transportation, by car? How did people get there?

HD: However. You got there yourself. A group of guys would get together, and maybe one guy would drive, and so forth. The group going out there. Otherwise you get there by yourself.

CBP: Did you get any experience doing home deliveries?

HD: Oh, yes. We did home deliveries.

CBP: Was that out of 48th Street?

HD: When your patient was due to deliver, she called you, and you went to her home. How did you get there? You got there! I mean, way out in South West, I remember. South Street, many times -- delivering babies down there. I delivered babies in places where they didn't even have stairs, I don't think. They used the stairs for firewood. Crazy stuff.

CBP: Did you go there yourself or with an attendant?

HD: No, there was no attending when you went there.

CBP: So as a medical student, you went by yourself?

HD: Unless you had trouble, you would call an attending. A medical student -- you went by yourself. The home deliveries were scheduled for uncomplicated cases. The complicated cases were scheduled to come into the hospital themselves.

CBP: But when it got complicated?

HD: That's what I say. You called on somebody. We had a lot of obstetrical training. I bet you I delivered three hundred and fifty babies in my

internship.

CBP: Who do you remember as the staff who trained you in obstetrics?

HD: Oh, to start with, H. Walter Evans, which the college is named after. William Barnhurst, Frank Gruber. Frank Gruber, especially. Les Eisenberg. Andrew Demasi, Nick Eni. We had a big obstetrical staff. I'm trying to think of the other guy -- he worked mainly at MET, but he worked at our hospital, too. A Jewish name. Sam -- I forget his last name. Sam spent a lot of time. We had a great obstetrical staff. We had one of the biggest in the city.

CBP: Did they teach you how to do a C section?

HD: Well, I got that in my residency. Well, we saw C sections as students -- sure. I did many caesareans as a resident.

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

HD: Well, as I told you, probably if we had greater quantity of clinical material. However -- you see,

I didn't even tell you that I would go to other places -- other hospitals, too.

CBP: Where else besides Norristown and ?

HD: Well, we went to the medical hospitals, too.

CBP: Tell me about that.

HD: We went to the morgue.

CBP: At which hospital?

HD: Lankenau was on West Philadelphia, on Gerard Avenue. They had great clinics down there -- surgical clinics. That was off the record, by the way.

CBP: How welcome were you?

HD: Oh, we were welcome. Oh, yes. In fact, my father as a student -- my father was in the 1920s, he used to go to these places -- they were welcome. I can remember my father talking about people. You don't have a medical background, do you? You're not a doctor, are you?

CBP: No. But I've been doing medical history for a long time.

HD: Are you a nurse?

CBP: No. I was married to a doctor.

HD: Well, you've got some training then. What was the question?

CBP: The experiences at these medical hospitals.

HD: I was talking about my father. The reason I started to ask you whether you had any medical training -- did you ever hear of a Dever retractor?

CBP: Well, I know about John B. Dever, the surgeon.

HD: At Lankenau, right?

CBP: Yes.

HD: Well, my father used to tell me about him. He was one of the greatest teachers ever. He used to go down there surgical , and he talked about these guys. Dever is one of the guys that started doing the appendectomies, for example. They , and they went to the University of Pennsylvania. We went all over.

CBP: You went to Penn's clinics?

HD: Yes. I didn't personally go. You see, I can't remember all -- remember I said we ran? If you wanted to learn, you ran. That's what I used to do. Wherever the stuff was, that's where I was. I think

if I would have been lazy, I wouldn't have learned as much as I did. It's not as easy as it is today to learn. But in many respects, I'm sure the students in my day are better than the students today because we learned directly from the physicians and we learned physical/surgical diagnosis much better than the young men are going to now, because we had to rely on those things. The favorite thing you'll hear from a student -- you ask him what are they going to do with their patient? Almost always is doing a MRI or a cat scan. We had nothing like that, so we had to physically diagnose the patient. We had great teachers -- that's the amazing part. We had great teachers and they weren't being paid. Every one would have a character that I'm sure they don't have today. Everybody is a character in their own right, but the greatest teachers were the characters who made you learn. I mean, you'd want to learn.

CBP: Who were some of those characters?

HD: Oh, God, we had a lot of them. I mentioned some of

them already. Jimmy Eaton, surgery.

CBP: Why do you call him a character? What was it about him?

HD: It would take me years to tell you about each one's personality. Jimmy had been a coal miner upstate. Jimmy Eaton -- one of the reasons was he was one of the first guys ever to use a light on his head. Well, you know, the coal miners did that. He didn't have to have people fixing the lights for him all the time because he adjusted to light in his head. He'd look into whatever he was doing. Jimmy used to always try to anger me somehow or get a rise out of me -- get an answer out of me -- and I would never answer him. One day he said to me, "Henry, what the hell is the matter with you? I can't get a rise out of you." He would intimate everybody. Nurses, students. He called the nurses by crazy names. Your name might be Mary; he'd call you Matilda or something. Instead of remembering everybody's name, he just called them by any name that came into head. He was an overpowering guy.

Arthur Flack was a finesse surgeon -- great surgeon. His father had been Dean. Arthur Flack, Sr. was Dean at PCO at one time, and Arthur Flack, Jr. was the surgeon, who did the first chest surgery -- thoracic surgery, and that's what I went into. I went into thoracic, and I started vascular surgery over there. All the time I was there -- cardiac surgery was in vogue before. The last thing we really got into was vascular surgery. Art Flack did some vascular surgery, along with the chest surgery, like we did aortic aneurysms and and defects in the heart wee did. But that was closed surgery in those days. So Arthur Flack I took a liking to because that was an areas I wanted to get into. But while I was a student and so forth, we did closed heart surgery. Not open. I used to try to get these guys to -- way back, I think if we had gotten a research situation there, we could have gotten the money from the government, and pushed in, we would have been into open heart surgery. One of the disappointments of my life was the fact that

when open heart surgery started, I wasn't prepared for it, and I just didn't feel like I wanted to go back. And then when I did get a residency offered, and had to go to South America for it because it was very difficult to get an open heart surgery residency. I think it was almost impossible for a D.O. to get into those things because there weren't that many, number one, and there was some prejudice there. I had already planned to go one year to Rio Dejunaro. A man named Jose . He told me he was going to take a year off. He took a year's sabbatical just when I was supposed to go, and I was within a month, ready to go. So I never got into the open heart surgery, so I was always disappointed because I wanted to be a heart surgeon. But I ended up doing lung surgery, and then we went into vascular surgery. So Art Flack was very instrumental in that. We had a guy in medicine, and I can't remember his name. My brother would know. Ask him who the great diagnostician was there. He was a character. I told you about Vic Fisher. Vic

Fisher was Chief of Cardiology. A very impressive teacher. I told you about Cathie in Anatomy. All our teachers were great. It's hard for me to -- do you have any specific questions? I think if you had more specific questions, I could tell you.

CBP: I actually have some other questions.

HD: Okay.

CBP: Given the perspective you have from your years on the faculty, please describe how the curriculum has evolved since the late 1940s.

HD: The osteopathic students always did the best on the national examinations. Every time we combined boards with medical students, we would do better. Like in New York, the combined boards. In fact, I remember, the last time I saw a statistic in 1965, we did much better than they did on the national boards. In other words, on the common boards and so forth -- every time we were in competition with them, we did better. There was a lot of reasons for that. First of all, I think PCO did a great job as teaching. We specifically over-taught. In fact, we

took extra courses. Of course, OMT -- osteopathic manipulation therapy -- was extra curriculum. But our guys always did good in exams. Maybe they studied better. I don't know he other thing -- the medical guys had a lot of foreign students, which, foreign students didn't do so hot in those exams, so that might have the statistics. But then there came a time with certain Deans, and I don't want to mention any names. They decided the students should decide what they're taught, which I thought that was a big mistake. You didn't have to take certain classes if you wanted to. Surgery was one of them. In that time we had a lot of students who were always interested in doing EKGs. Well, hell, we had the best EKG-taught students. My brother was one of the teachers, of course. Because they all went to those classes. They didn't have to attend my lectures in thoracic surgery, for example. So you had electives, so that then the curriculum again, wasn't as diversified as it was before, because students had the power to pick your classes

in the senior year or junior year, or whatever.

CBP: What time frame was this?

HD: We're talking about the 1960s and 1970s. That was a big disappointment because then we realized we were graduating students, like the medical students were. We're specialists -- we're oriented now, rather than total medicine oriented. I though that was a big mistake. However, our guys all went into the specialties, and that's the way the things are going today. I can give you an example. In surgery -- I was taught in general surgery -- all phases of surgery. I was licensed and certified in general surgery. I could do practically anything. I didn't elect to do neuro-surgery, for example, but everything else I did. And in time, I selectively picked what I want. But the surgeries that I taught are all super-specialists. In other words, they're in a small area. So now you've got a physician, you've got something the matter with your little finger, you got to go to him. But if you've got something the matter with his thumb, he can't take

care of the thumb. I'm exaggerating a little bit. but the point is, as far as I can see, we're not turning out the type of student -- in those days, our guys were oriented -- total patient oriented.

CBP: Although now there seems to be towards family practice.

HD: Well, that's another political thing. We always were family practice oriented because most of the medical -- conventional medical people -- most of those go into specialties, and we always were more heavily tilted towards general practice. What was your question again?

CBP: How did the curriculum change over the years?

HD: Well, that's the way it changed. For example, a student of today doesn't know -- has no idea what we learned -- and I don't think they're being oriented that way because everything is towards keeping people out of the hospital. [laughs] Keeping people away from treatment. In those days we were always oriented toward treating patients first; not worried about the bucks and everything else. So all

things being dictated by the dollar, and what I'm afraid of, and I'm sure everybody else is, too, if you talk to the physicians, that it's become a business. And a business is just out there to make money. So that's where things have changed. And I think it's because of the curriculum change. One of the things we do by making all these super specialists -- we actually increase the price of medicine.

CBP: I want to shift gears now. I want to talk to you about your experiences as a medical student, not academic.

HD: You're talking to a guy that's seventy years old here.

CBP: Do you have a memory?

HD: Sure, I have a memory!

CBP: What were the highlights of your social experience at PCOM in the 1940s?

HD: I thought you were interviewing me about surgery. What is this social?

CBP: I want to know about of a medical student,

before you were a surgeon.

HD: My dear, my specialty is surgery, not social.

CBP: But you hadn't specialized yet when you were a medical student.

HD: No kidding. But I already knew what I wanted to do. I always wanted to be a doctor. I always knew what I wanted to do. I didn't get married until I was forty, so I wasn't socially oriented, even to this day. But I thought I was giving you a surgical history, and you're going into areas I'd be very happy to tell you about, but I'm a surgeon.

CBP: Well, we're going to get to some more questions about surgery, but I wanted to talk about what it was like being a medical student.

HD: Well, we had fraternities, which I belonged to one. I was in a fraternity. We had dances. We had affairs to go to. We had a senior dance, which I went to. I went to all the social functions. Is there anything else you want to talk about? The usual school functions. We had a charity ball -- the college and the hospital -- every year we went

to. There were a lot of social functions.

CBP: Women were absent from the graduating Class of 1951, and they were present in the smallest number at any time during --

HD: This is going to be women-oriented?

CBP: This is just a question.

HD: Why don't you ask me about how many women were in my father's class in 1927.

CBP: My question is getting to there used to be a lot more women at PCOM, in earlier years, than there were in the 1950s.

HD: Do you know why?

CBP: I'm asking you.

HD: Because the guys coming out of the Army had preference, that's why. That was part of the G.I. Bill. Now, that had nothing to do with women, because my father had about thirteen women in his class, in 1927. We always were women-oriented. My wife is a D.O. Women-oriented.

CBP: So the G.I. Bill is what impacted --

HD: Well, since you asked the question it just came up.

But that had to be a factor. For example, I didn't get into Temple, which I was promised I'd be in there, because he G.I. guys took over. Women weren't medically oriented in those days, believe me. But they were, in our school, way long before M.D.s.

CBP: Let's talk about surgery now.

HD: [laughs] I just didn't want to go off in some socialistic jargon here.

CBP: When did surgery become a specialty within osteopathy?

HD: In the 1930s. You mean with a Board, and all that stuff?

CBP: When did someone who was a D.O. practice almost exclusively surgery versus being a general practitioner and only do surgery?

HD: Always. We always practiced medicine in surgery. We always practiced obstetrics. We always practiced everything. So there's your answer.

CBP: But when would a given D.O. elect to only practice surgery, and not also be a general practitioner?

When did it become ?

HD: In the early part of the century. You've got to understand, last century there was no surgery. It all started -- the average medical school -- do you know what the average medical school was in 1900? How many years do you think?

CBP: How many years was the education?

HD: Yes. I mean, how long did you have to go to school in a medical school in 1900?

CBP: I think at that point it was two years, and then the Flexner Report brings it up to three or three to four.

HD: No. One year. That was the average. And the best schools had two years. And do you know what the second year was?

CBP: Clinical?

HD: A repeat of the first year. I don't want to tell you what you've heard, but that's the truth. The first improvement was the first year was repeated to make it two. Now, you're talking about the Flexner Report, you're talking about the 1940s, aren't you?

CBP: No, 1910.

HD: What is the Flexner Report? What is your understanding?

CBP: That it was looking at standards of medical education.

HD: Increased to three years in 1910?

CBP: I believe that was increased to three years.

HD: I'm sure that's true. I was talking about 1910.

CBP: I think they also addressed the curriculum and certain things that really had to be .

HD: You've got to understand medicine started turning, really, since worked with people like , and things like that. Osteopathy was founded before that. So as far as I know, we always practiced surgery. Obstetrics and so forth.

CBP: What role did PCOM play in the development of surgery as a specialty?

HD: You mean our first residency? Is that what you're talking about?

CBP: Yes.

HD: You're talking about the stuff that came in the

later years, as I say. I think the first meeting of the American College of Surgeons was probably in the late 1920s, and that's when the Licensing Board and the Certification Board started. But there were people practicing surgery and surgery alone before that. That's what I was trying to say. What was your last question?

CBP: The question was what role did PCOM play, if any, in leading surgery?

HD: Well, we had some great surgeons. Our guys -- I mentioned Dr. Eaton -- was a Chairman of Board of Surgery. Before him Dr. Drew -- Ed Drew -- was one of the founding members of the College of Surgeons. It goes back to the late 1920s or early 1930s. We always practiced surgery at PCO, as it was called in those days. We were part of the founding fathers, as far as surgery is concerned, and always have been. We took part in all of that.

CBP: What kind of training did you receive in surgery, after concluding your four years of medical education at PCOM? For instance, internship,

residency? How did you get your surgical residency?

HD: Well, for one thing we had the internship. Of course, it was a rotating internship. We rotated through every department.

CBP: Was that a one year internship?

HD: Yes. And that was the first year of my -- as you know, the medical people -- they specialty the first year. Of course, you've got to understand, when you're thinking about a specialty, you're thinking about that anyway, from the time you end up. Do you want to know about my surgical training? Is that what you said?

CBP: Yes.

HD: I had great surgical training. First of all, I had to be first assist, and within two years, I had to have three hundred cases. Well, by October of my second year, I already had three hundred and fifty cases.

CBP: This is during your residency?

HD: Yes. I was the first assistant or did the surgery. Three hundred and fifty cases. That's before you

could take your boards. Remember, we're going back to the fact that you had to take boards to get your license in surgery. So just to show you how many cases I had, I had three hundred and fifty cases documented by October, and I had many more after that. So I probably might have had four hundred and fifty. So I had plenty of training with diagnosis. I went through the whole gamut. Diagnosis. Followed the patients. One thing we didn't have as much of, and we would have liked to have done more ourselves, but I found that I can manipulate doctors, so that I did things as a resident that had never been done before, since I started surgery, and I've done a lot of new things in surgery, so we were always developing. I remember one year into my residency I did a radical mastectomy, and the woman was living twenty years later. I did it in front of the amphitheater students. That's one of the things you did in your junior and senior year. You went to surgical amphitheater on Saturday mornings, all morning. You had surgical clinics and surgery. It

was a clinic case. I did a nephrectomy. Things like that. I did a nephrectomy on a six-year-old during my first year, so I started out there. I think it's because I worked so hard. The guys let you do. But we would have liked to have had more work where we could have done it all ourselves.

CBP: How many years was the residency?

HD: I was the first one that took three years in general surgery, as a resident. People took fellowships.

CBP: Was that the ?

HD: When I was a resident, two years was the requirement.

CBP: And you did three years?

HD: I did three.

CBP: Then did three years become a requirement?

HD: Oh, yes. It's up to five now. Oh, yes.

CBP: Could you describe the development of the evolution of the surgical residency program at PCOM?

HD: Well, for example, when I finished my second year and applied for the third year, there was a big discussion because they had no third year program.

Dr. Eaton said, "Henry, we don't have a third year program. Draw up a third year program." And he said, "When you draw it up, give it to me, and we'll go over it and all the surgeons will go over it, and then we'll modify it." That's what happened. I outlined the first third year program. The third year program said that I did more surgery on my own, that I had a selection of what cases were being done. So I had a lot to say. I was also Chief Resident for a while, too.

CBP: At what point did a three year residency become mandatory?

HD: You know, I don't even remember the exact dates on that. In the '70s.

CBP: It went up to three years?

HD: Yes. In the '70s it went to three years.

CBP: How about four years or five years?

HD: Right after that. Every four or five years it seems to get worse.

CBP: To your knowledge, was PCOM the first osteopathic college to offer a surgical residency?

HD: I don't think so. No. I think they had them at Deitchwick before. I know who the first resident was.

CBP: Who was that?

HD: You see, before that they had fellowships. The first resident was a guy in medicine. He was chief resident. He lives down in Miami Beach.

CBP: Morton?

HD: Morter. He was the first resident that the AOA approved, and that was in the '40s.

CBP: That was in 1945.

HD: Was it?

CBP: Yes.

HD: That's probably right. Now, the first surgical residency was right after that. It might have been the following year. Do you know better?

CBP: I don't know. That's something I'm trying to find out. I'm asking you.

HD: Oh, I see. Right after that.

CBP: Who was PCOM's first surgical resident?

HD: It might have been Art Flack. I'm not sure.

CBP: To the best of your knowledge, how did your surgical training in the 1950s differ from that of an allopathic surgeon?

HD: Probably the allopathic surgeon had the ability to -- and I'm not sure exactly when it started -- I think they had a better clinical group -- more numbers. That's probably all. That's all. Just probably the numbers and doing the stuff by themselves. But as I say, I did everything, and by working into it, I did more than anybody before me, and many of the people since. It wasn't an actual program in numbers, and doing the residency until probably the '60s.

CBP: But when you were a surgical resident, how many surgical residents were there?

HD: When I was a surgical resident, Vince Apall was a surgical resident, John Frank was a surgical resident, and Bob Friedman. There were four.

CBP: Spaced over two years or before your year of residency?

HD: Well, Vince Apall -- when I was an intern, he became

a surgical resident, so there's overlapping. Before him, Magliari was a resident in surgery. I think we had two surgical residents. Bob Magliari from Norristown was a resident. We always had two or three residents. Jerry Axelrod was a resident in surgery, but you've got to understand we had residents in urological surgery and so forth. You ask me surgery -- I'm thinking general surgery. I'm thinking general surgery when I'm answering you. Axelrod was in general surgery, but Ed Dimasi was an OB/GYN, and so was Nick Eenni. Orthopedic surgery -- Bob Friedman went into that eventually, but there were four general surgical residencies during my time. I was one of the four. One of the reasons we had four was we took over North Center, another hospital.

CBP: Were the four who would start each year, or was it two that were there as first-year residents, and then two were accepted for the next year? I'm trying to get out what was the size of the residency group.

HD: As I say, while I was there -- before I started -- in general surgery there was Axelrod. I can't come up with another one in general surgery. But when I was a resident, there were four.

CBP: Four total?

HD: Four total in general surgery. Four total. That's right. But before that it was like two or three. I started in 1951, and there were four in my group.

[end of side one]

CBP: The question was how many surgical residents were each year?

HD: General surgical residents -- just before I started, there were two or three general surgery residents. When I started we had four, and we were all first year men in general surgery. It just happened that way because I think the approval went up to four at that time because we had the additional hospital.

CBP: Right. That leads to my next question. Norristown.

HD: Yes. Norristown.

CBP: Before I ask you that question, though, was there a call schedule for surgical residents?

HD: Oh, certainly.

CBP: What was the call schedule?

HD: You're not going to believe this. I'm sure you're not. When I worked thirty-six hours out of every forty-eight, I was on, in the , working.

CBP: Did you live in the dormitories?

HD: Yes, on the fourth floor. All down the street. We had a house down the street, 4600 or 4650 -- something like that.

CBP: Was this just for residents?

HD: Interns and residents. It was like a four-story house there. Interns and residents occupied that space when you weren't on duty. But when you were on duty, we had quarters on the fourth floor.

CBP: That was the dormitory?

HD: Yes. Where you could sleep. Of course, if you were on, you were waking up all the time, if you ever got to sleep. But sure, we had on-call.

CBP: And that was seven days a week?

HD: We used to get a half a weekend. Do you know what a half a weekend meant? When we got off it was a half a weekend. That means Saturday noon until Sunday noon. That's a half a weekend. It was twenty-four hours. A lot of half of one day and the top half of the next. That's the time off we got for the week. As I say, I worked for three years on this schedule, which these young people -- I keep thinking of you as a medical student, and I don't know why. My minds works funny.

CBP: I'm too old to be a medical student.

HD: No, you're not! A guy in my class was forty-two when he graduated.

CBP: Well, he's a little bit older.

HD: [laughs] A little bit! I'm sure that's not true. Believe me, for three years -- even when I was Chief Resident -- I worked thirty-six out of every forty-eight hours and got a half weekend off. I forget whether it was once a month, or what.

CBP: Could you describe the surgical clinics at the 48th and Spruce Hospital and also the North Center

Hospital? I would like to get an understanding of the respective roles of the medical student, the intern and the resident.

HD: Well, we had surgical clinics at both places, held once a week. One hospital was twice a week.

CBP: One was on Saturday?

HD: No. You were talking about the students -- the amphitheater. That was for students. That was four third and fourth year students. We're talking about the graduates now. No, we're not. We're talking about the same thing.

CBP: We are?

HD: The amphitheater surgery was on a Saturday. This was in addition to that. There was a surgical clinic at 48th Street and there was one at 20th Street. We're in different days so that I could get the . You had definite assignments to the clinic, besides. They were usually in the later part of the day -- in the afternoon and evening. As I say, they were two different days. There were always attendings there. In the surgical, you

always had what they called a junior surgeon and a senior surgeon. The junior surgeon was always there. The senior surgeon may or may not be there, depending on the situations. In those days, if you had to lecture to a class, that took precedence over everything, except surgery itself. If you had a surgical case, that took precedence, so that you had to be there. So we had ways of covering each other. When a guy couldn't make the clinic when he was a junior, he'd get somebody else to take his place. "I'm going to do this case, can you handle this?" and so forth. But there was always a junior, and most of the time, a senior man, at those clinics. And the resident who ran the clinic for these guys in attendance. And you've got to understand, in a clinic, the student will bring his patient. He would generally be there, too.

CBP: I'm confused now. There was a junior surgeon, a senior surgeon and a resident?

HD: Yes.

CBP: What is the hierarchy of those three?

HD: Well, exactly what I say. The junior surgeon is a surgeon.

CBP: So he's the one who has finished his residency training?

HD: Yes, this guy is in practice, but he hasn't achieved senior surgeon status yet. But as senior surgeon, when we have a clinic case and we're going in the operating room -- you see, you're talking about the clinic. Are you talking about the operating room or are you talking about the clinic?

CBP: Clinic.

HD: In the clinic, as I say -- every month you had this list of who was covering the clinics, and the guy covering the clinics also covered the surgery in the hospital. And there was a senior and a junior. Now, the senior surgeon wasn't always there. Or, for example, when we did a clinic case maybe on a Saturday morning in the amphitheater -- of course, we had two or three operating rooms. But in front of the students we had this amphitheater just for the juniors and seniors. For example, if you had a

case to do, you were the resident, you worked the case off. You would call your junior man. Now, if the junior man, for some reason, thought he couldn't handle the case by himself, he'd call the senior guy in. So when you did the actual surgery, that junior guy was always there with the resident.

CBP: Was the surgical clinic just a diagnostic?

HD: Both.

CBP: Or was it also doing the surgery?

HD: As I said, both. On the list, the guy who covered the clinic, covered the clinic in the college, and covered the clinical cases when they went in the hospital. So that guy was in charge. And the resident who was in charge that month -- those guys were all listed, and you always knew who was responsible.

CBP: What do you remember about the North Center Hospital, such as the neighborhood, who the patient population was?

HD: The first thing I remember about the place was we took it over just as I graduated. About a month or

two before I graduated, we took over North Center. So this was a plus because we had a lot more clinical cases now. But one thing they had done -- the medical group that owned that hospital before had lost a lot of money through their emergency room. The first thing PCO did was "shut the emergency room," so to speak. In quotes I'm saying that because people would show up anyway, even though we were closed. We've operated on people laying on the floor in clinics that came in through the emergency room because they didn't know we were closed. That was closed right off the bat. Why did I tell you that? This is what I remember. However, our clinics were always chock full of patients up there, but the emergency room there was closed for many years. We had an emergency room at 48th Street. By getting this North Center Hospital, we had a lot of clinical cases added, for us to cover. And because of the logistics of the whole thing, these attendings couldn't be six places at one time, so therefore, you were called to do things. For

example, in my internship, two days a week we do T&As. Well, we would do fifteen or twenty T&As on a Tuesday.

CBP: Explain T&A, please.

HD: Tonsillectomy and adenoidectomy. We used to do a lot of T&As before antibiotics knocked out these diseases for tonsils, and so forth. For example, right away I could do a T&A. We had so many T&As, you almost -- if you were any good -- you watch one or two, and the next one you did. Well, if you had fifteen or twenty to do in a day, maybe you would give the anesthesia. You would rotate on anesthesia once in a while, just to get the experiences. These open-drop ether anesthesia in those days. So I did a lot of tonsillectomies and I did a lot of deliveries. I'm sure I did over three hundred deliveries, I guess, during my internship and residency, because I started out as a OB/GYN, and then I switched over to general. But the first two years of both of those residencies were general surgery residencies. Like, for example, the guy who

went into E&T -- he had to take two years of general. The guy who went into orthopedics had to take two years. So all these guys started with me, but they didn't all -- I took the third year. All these things were set-up.

CBP: We're talking about North Center now.

HD: Yes.

CBP: Tell me a little bit more about the hospital and the neighborhood it was in.

HD: Well, it was in a poor neighborhood -- mostly black neighborhood.

CBP: Were these paying patients?

HD: No, most of them didn't pay at all.

CBP: How was the hospital being supported when you didn't have paying patients?

HD: Well, quite soon after we got there, somebody came from the state. And in those days -- you see, they were taking a lot of private patients over there because we were so crowded at 48th Street, we couldn't get in there, we'd send them over there. But then they took the clinical beds there, and we

were given money by the state. But if you didn't use that money, the following year -- the amount would go down. And I remember arguing with Dr. Ebbotts, who was one of the big-wigs -- you know, you didn't spend the money. You see, what happened? I told you if you would have spent the money, we would have gotten more money. Now you say we don't have any money, but it's our own fault. You know, everybody is the day. If you're taking advantage of the government, you can get all this freedom. For example, the research building. If you're taking advantage of the government, we could have had a research building before we had a new college, but they thought the new college was more important. So that what North Center did for us -- it added a lot of surgical cases, it added a lot more experience, it delivered a lot of babies. I did a lot of surgery I would have never been able to do, even when I planned to be a surgeon because of that North Center.

CBP: What became of North Center?

HD: We finally sold it.

CBP: When and why?

HD: We sold it soon after we moved to City Line Avenue.

CBP: Was that because you would get enough beds in a new hospital?

HD: Yes, I think so. And by this time, what had happened -- for so long we so badly -- the osteopaths -- that they went out and opened their own hospital. Parkview, Tri-County, Suburban General. In the beginning they were coming to PCO, and then gradually, the D.O.s in the area were sending them to all these hospitals, so we deluded our bay, so we didn't need North Center, plus the fact that North Center, I think, was getting so old that a lot of changes had to be made. It didn't pay to keep it. By that time we had plenty more places our students went to -- and our interns and residents.

CBP: Do you remember anything about the bed tax at 48th and Spruce?

HD: Oh, sure.

CBP: Can you tell me about that?

HD: Oh, sure! First of all, when I joined the staff, it cost me two thousand dollars to join the staff.

CBP: A one-time fee?

HD: Yes. Then, every time you put a patient in -- I think a surgical case you paid a dollar. Everybody was allotted so many beds at 48th Street. So when North Center opened, it opened up a lot of beds. Believe it or not, when I started practice, do you know what my allotment was -- at 48th Street? One-half a bed a day. Now, how do you do that? Do you see what I mean? See how they throw the guys away. In order to put one patient in, somebody had to say, "Okay, you can on my allotment."

CBP: Was there such a shortage of beds?

HD: Yes, at 48th Street. Jimmy Eaton would have ten beds because he was Chief of Surgery. Art Flack would have six or seven. I got one-half. But when North Center opened up, of course, I could take them to North Center a lot easier.

CBP: Was there a bed tax at North Center?

HD: Oh, yes. Bed tax was for all places. Medical case paid less a day than a surgical case, but as I recall, we paid a dollar a day. So it behooved us to get the patient out of the hospital. We've been doing it for years. But my Chief, Dr. Flack -- we used to send patients -- first of all, the first day we got them out of bed. Nobody did it in those days. We did it. Some of the surgeons would keep the patients in bed for two weeks before they got them out of bed! We'd get them out the same day, and a lot of -- he did a lot of hysterectomies and so forth. Most of those patients went home in three days. More or less like it's done today. One of the reasons Flack was just a cheapskate -- he didn't want to give them a dollar a day. He figured the more they stayed in, the less money he made.

CBP: Was it a flat dollar a day, or a flat per patient?

HD: No, no. Per day.

CBP: Then what difference did it make which patient it was? Either way you had to pay your bed tax.

HD: Yes, but if you could get a patient out in three

days, you could get another patient in. And you'd get a surgical fee.

CBP: Oh, you'd get a surgical fee.

HD: So why keep a patient in a week if they didn't have to be there a week?

CBP: When did this practice of the bed tax stop?

HD: Well, when I started it cost me two thousand dollars to join. I remember when my brother started it only cost him one thousand to get on the staff, and he graduated in 1956, and he started practicing in 1960, I guess. At first it went down a little. I don't know exactly. I can't remember exactly when it stopped. Probably in the middle-'60s.

CBP: Was there a bed tax at the City Avenue Hospital?

HD: No.

CBP: So then it stopped by the time --

HD: By the time we went there. What was the cornerstone there? 1967?

CBP: No, it's earlier than that. I think it's 1963. I'd have to check.

HD: No, it's not 1963.

CBP: Well, the hospital went up first over there.

HD: Yes, I know, but it wasn't 1963. In fact, I think the hospital opened there in 1968. But we actually got it to say 1967 on the wall. That's my recollection.

CBP: Okay. So regardless, there was no bed tax?

HD: No, I don't think so. No, I don't recall it being there. That might have been the time it stopped.

CBP: I'd like to talk to you about surgical subspecialties. You mentioned that you got into cardio-thoracic surgery and then vascular surgery.

HD: Yes.

CBP: Please describe how these subspecialties work?

HD: Well, you've got to understand that the cardiac surgery -- for example, Charlie Bailey worked at North Center when that was called Women's Homeopathic, and Charlie Bailey -- he and a guy in Boston were the two founders of closed-heart surgery. Mitral Commisurtomy -- he started in the late '40s, and the first case he did -- Mitral Commisurtomy was at North Center Hospital.

CBP: What does that mean?

HD: The micro-valve has two flats. In Rheumatic Fever, the flaps become inherent and become stenosed. So, in other words, instead of being open, when they open, they open like his, they become stenosed. The hole becomes smaller and smaller, from the build-up, and so forth. We could, in those days, put your finger into the heart and many times, just by pressure, split the flaps open, and if necessary, you put a glove on with a hole in the finger, and we slip a knife down -- like a guillotine knife, that you control from here, and you put your finger in the heart with a tourniquet around your finger, and you could cut, so that you cut that so-called , where the leaflets came together. You cut it open and allow the flaps to move and open and close. We were doing that type of surgery in the '50s. It started, as I say, in the '40s. Charlie Bailey, who was the great pioneer -- he was a great friend of Art Flack, and part of my residency I went down with Art Flack and with Charlie Bailey, so we learned how

to do heart surgery down there. We had great friends down there. One of my residency -- especially in my senior year -- if I had time, I just went right over there and watched these, and scrubbed in a couple of times. Art Flack used to scrub in all the time. What was the question?

CBP: I wanted just to find out about the development of surgical subspecialties at PCOM.

HD: Well, that's when heart surgery started, in the early '50s. Art Flack was doing lung surgery already, and of course, that's where I learned all of that -- from him.

CBP: How about vascular?

HD: You see, in those days, we had what's called a aorta in babies and some adults. The aorta gets small. We used to go in and clamp it off, and cut that section out and sew the ends together. Or, if necessary, put a in it. We were doing that in the '50s. We did things like . Do you know what that is?

CBP: No.

HD: -- that's a between the pulmonary artery and the aorta that is abnormal, and general . We used to do that operation on the heart. We did for , and sling operation. We did ectomies. We did a lot of heart surgery in the '50s, and that was part of my training. And lung surgery. Now, vascular surgery -- I had some experience with vascular surgery. The stuff I talked about -- the aorta, for example. In 1960 I went for thirteen weeks to a hospital in New Jersey. I took a course in vascular surgery, and we learned on dogs, and so forth. We had a terrific course. I and Dr. Herman Kohn went up there. And in the meantime, I spent a lot of time with my cousin, who was Chief of Vascular Surgery at Pennsylvania Hospital. At that time he was at Hahnemann.

CBP: Who was that?

HD: Dominic DeLarentis. He's still Chief of Vascular Surgery over there, I believe. He was Chief of Surgery at the Pennsylvania Hospital. He's related

on my mother's and father's side, so he's a cousin of mine. His mother was a D'Alonzo. Anyway, I used to go to Temple and Pennsylvania Hospital, so I learned a lot of vascular surgery from him, and the other guys at Temple. I can't think of the other guy's name, but the man is Dominic DeLarentis, who is one of the big vascular surgeons in the nation. I started developing the vascular surgery at PCOM.

CBP: Tell me again what year this was.

HD: I started in 1960. I got that training up there, plus the training I had already had. I would think that actually in 1966 you could say. I did a ruptured aortic aneurism that survived. Everybody was amazed that the guy survived, in the middle of the night up there, at 48th Street. That was right after I got married. I got married in April, and I think it was 8/6/66, the way I remember it -- the date of that operation. From then on, vascular surgery. I went into that subspecialty with general and thoracic.

CBP: How about other subspecialties at PCOM, such as urology?

HD: Urology was there when I got there. Dr. H. Willard Sterrett was Chief of Urology, and his son,Willard Sterrett, Jr. Bob Winney was after that. Oh, yes. Urology. We had orthopedic subspecialty, we had urology.

CBP: Who was the leader at at PCOM?

HD: Dr. Eaton. James Madison Eaton. He was a general surgeon. Everybody was a general surgeon originally.

CBP: Given the context of when you started doing vascular surgery at PCOM, when Eaton was doing orthopedic surgery at PCOM, how was PCOM compared to other osteopathic colleges and hospitals? Were you a leader?

HD: One of the leaders -- yes.

CBP: Could you clearly say if you were <u>the</u> leader in any of these given subspecialties?

HD: I would say Art Flack started the thoracic before anybody else.

CBP: How about vascular?

HD: I was probably the first one in this area. I'm not sure if anybody started some place else before I did, but I was the leader in this area, and cardiac pacemakers -- I did the first cardiac pacemakers. I think I started in 1964/1965.

CBP: Among osteopathic hospitals?

HD: Yes. At least east of the Mississippi. There was a guy doing pacemakers in Detroit. DeMarco. But I was probably one of the first ones, if not the first. We did a lot of firsts. When I was a resident, we did the first exchange transfusion on a R.H. negative baby. Myself and Dr. . Do you know Lou , from Detroit? He was a resident in pediatrics, and I was a resident in surgery, and we did the first exchange transfusion we ever did in the whole profession.

CBP: When you say profession, are you distinguishing between osteopathic and allopathic?

HD: Yes. Do you know what year I'm talking about now? I'm talking about 1954.

CBP: Tell me some other firsts.

HD: Well, I did the first aortic aneurysms.

CBP: Osteopathic?

HD: Yes. I did a heck of a lot of firsts. Well, you understand, surgery was advancing and so forth. I learned from somebody else, of course, and devised a lot, myself. Pacemakers. I did everything. The first in the profession. Every time I'd operate, I'd be doing the first in the profession or something, when vascular . Different techniques in surgery. We started with the machines -- the staplers. We were one of the first with that. But I can't say in the whole medical profession. The first in our profession, of course. You see, one of the advantages they had -- these companies would go to them first with the new advances, and so forth, and these guys got these contracts with these people, and so they made a little money out of it, too, so you could devote some time to that. But if we'd have had that, we'd be doing cardiac surgery. If we'd have had a

research facility development. For example, I worked at Temple a lot, and I saw how they did their heart surgery. You see, each department had a floor over there in the Research Building, and they were doing these operations on animals -- calves, apes, and smaller. For example, they used one heart/lung machine that would take care of a small animal. That would also take care of a small child. And you had all these technicians working, and you had a grant from the government which built the facility, and also you had a grant that paid these guys because of the research, got money from the government to pay the -- I kept telling these guys, "Listen, you can pay these guys for doing the research, the same time , same stipend, and it doesn't come out of your pocket. The government pays for it." But our guys were busy talking about building a new hospital first, and other things, and it just didn't look as far as I had because at Temple, I saw how it looked. My cousin, for example, was, at that time, an Assistant Professor

of Surgery.

CBP: DeLarentis?

HD: DeLarentis. Yes. And he was doing research over there, and he showed me how it worked. Now, when he started to do these things on humans -- if you worked on a child, you used one pump. For an adult, you might need four series. This is the way these heart/lung machines started. So it was just a matter -- you just took your crew from the research building and you brought them in the hospital, and you saw it. In other words, you just can't say, "We're going to do heart surgery," and go back, because you know you've got to hire all the people. Anyway, we'd be doing heart surgery today if we had a little more imagination, and a little more time, maybe.

CBP: I want to shift now into a different line of discussion. Get off of surgery and back to PCOM as an institution. Your four plus decades at PCOM take you back to the Barth era, 1957-1974 --

HD: Oh, he was there before that.

CBP: As Chairman of the Board?

HD: Yes.

CBP: But as far as being President, please comment on Dr. Barth as a leader, and the highlight of his administration.

HD: He was a politician and the strange part about it was he was a Republican, and yet we were getting money from Democratic administration, so I don't know how the hell they , I don't know. He was the leader in the fact that his administration got the money to build the hospital on City Line Avenue.

CBP: Were you aware of the original plans to expand in West Philadelphia at 47th and Spruce?

HD: Since I was a little kid. They always had plans.

CBP: Why did that fall through?

HD: I don't know. Probably because of the Depression, originally. Because I saw skyscrapers when I was a kid walking into those offices over there. They've got pictures of the plant. Why did that fall through? The money wasn't available. We didn't have enough money. You've got to understand, our

profession was financed by the doctors themselves for many years.

CBP: But there was land at 47th and Spruce that wasn't even purchased until 1953 or 1954, with the idea of expanding 47th and Spruce.

HD: Yes, you're right.

CBP: And they didn't build on it, and instead, Barth took you out to City Avenue.

HD: That's right. Why did that happen, did you say?

CBP: If you had any insights about that time period.

HD: Well, yes. It was up to the board. If you've got power on the board, it's all politics, I'm telling you. [laugh] Do you know how these things really work? Whoever is in power -- there's money to be made. I shouldn't probably be talking about this. But that's off the cuff, but that's the way it happens. For example, Barth told me personally that we were getting City Line Avenue for three hundred thousand dollars, and it was thirteen acres around it. It was a hell of a buy. Art Flack and I were eating lunch across the street and we said, "We're

going to get that, and the deal is going through -- three hundred thousand." Well, it took them six months for that deal to go, and when it went through, it was something like six hundred and fifty thousand. So what happened between three hundred and six hundred and fifty? Somebody made some money. So there's politics in there. Do you follow me?

CBP: Yes.

HD: "If we can get it for three hundred, why the hell are we paying six-fifty for it?" I'm on the outside looking in at that time. I was on the Board later, and I got on the Board for three years, when I became Chairman of Staff, and then I understood how the Board works. Most of the people on the Board have very little to say. These things concern me.

CBP: Highlights of the Barth administration.

HD: Well, politics. For example, he became Postmaster General for Philadelphia. Barth had been a millionaire and lost it, and became a millionaire again -- business. And he was a businessman we

needed over there. He was pretty dictatorial, I would say. He had Tom Rowland working for him, and then it came a time when it looked like Tom Rowland was running everything, but Barth had the veto, so that he ran everything. He was the one to tell the doctors what to do. He became a powerful man. For example, I tried to talk him into building a research building for two hours, and he finally said, "I just don't have the time." I said, "Well, look. You get the people to do it. I'm one of them. Let's go." No. I couldn't talk him into it. He was too busy with the other things.

CBP: There was a research facility on the initial plans that were laid out for the building campaign for City Avenue.

HD: Yes, I know.

CBP: That and a dormitory and a nursing home.

HD: Yes, but it was , compared to what I'm talking about. I'm talking about . I'm talking about a five-to-seven story building that the government would have paid for. And it would

have helped every department in the hospital. And we would have had by now what Temple has, what the University of Pennsylvania has. It's all paid for. Johnson administration had this big commission. They put Debakke in charge. They built three hundred-and-some cardiac centers with all this money, and they built all kinds of things. Because they weren't going after heart disease and stroke, and so forth. Did you ever hear of Mike Debakke?

CBP: Yes.

HD: Mike Debakke was put in charge of that. And yet, after they built all of thee hundreds of places, only ten percent of the places -- like thirty of those hospitals -- were doing anything to talk about, and thirty places were doing better than ninety percent of the cardiac surgery, and yet they had all of these hundreds of facilities, and we had none. That's my point. We could have been on that because as an osteopath, we didn't have one. I think that's one of the places we made a mistake, and it's always been one of my pet peeves. Because

I would have been highlighted there. [laughs] One of the reasons being that I had the training, and I could have gone right into it.

CBP: In December of 1974, Thomas Rowland was inaugurated as PCOM's fourth president.

HD: I've known him since I was a kid.

CBP: Comment on his strengths and weaknesses as a leader and the highlights of his administration.

HD: Well, he was another guy that was in charge. Very dictatorial. He ran everything. Everything you knew, you had to come back to him and tell him what was going on. Tom had a lot of advisors, but Tom came from a political background, and he was ward leader in North Philly, and he was a delegate to the Republican Party, so he had a lot of power to pick the President, and so forth. So he was politically motivated, too. Do you have any idea how in the old days we used to run a ward or a district in politics? You had a local committee man, and these guys all met, and you had a ward leader, and the ward leader . Well, he was into that, and

he ran it like he was a ward leader, and since we were kids we were saying, "This guy is going to be Mayor of Philadelphia," which he never became, but he took over Barth. But he was really running PCO -- - Barth -- at that time, before he took over.

CBP: Rowland was running it, or Barth?

HD: He was running it in the background, with Barth as the figure-head. In other words, he was doing all the legwork, and Barth had all the veto power. I had a lot of insight there because he's a friend of mine, and we saw how it worked. We knew who was in charge. You had to go to Tom, and Tom would give you approval, but he could be vetoed. He ran a good administration, except as a politician, he had his key guys -- his cronies is the way to put it. So Tom started at the Registrar's Office in 1950. Well, in 1950 I was in my senior year at PCOM, so I was at PCOM before Tom. And Tom got there because of Barth. We used to call him Uncle Fred. But he wasn't an uncle, he was a friend of his mother's. He taught in the Baptist Sunday school Tom Rowland

went to. He used to call him Uncle Fred. That's how close they were. That's how Tom came in there -- it was a real surprise because we , but he came in suddenly. Suddenly he had a job at PCO as Registrar. Tom made a lot of friends. A lot of people used him, but he'll go down as one of the best leaders we ever had.

CBP: What were some of the highlights of his years as President?

HD: Well, believe it or not, you know that 4190 building? That was built as an office building. Not by us. Do you know the story about that?

CBP: Yes.

HD: I'm one of the guys that said, "Look, Tom. You got to take over that place because so far they only rented out one floor." I was with a group of ten or twelve doctors going in there, and they said they had to at least rent out one floor before they'd open an office building. So we're waiting for years to get this office building. My brother, Ray Rueberg, Nick Nicholas. You don't know Ray Rueberg,

probably.

CBP: No, but I recognize Nick Nicholas' name.

HD: Yes. And on and on. We had a real big group. Jerry Solman. We had a group that was going in there. I said, "Look, PCO ought to take that building over," and he did. He finally took it over and he got a lot of donations from everybody. And then when he opened the building, he only would rent offices to people that were on the payroll. [laughs] That always annoyed me because I was very instrumental in him buying that building. And I also donated money -- forty-one hundred and ninety dollars -- for that -- you'll see my name on a plaque over there, on the bottom floor, thinking I was going to get an office in there. Then they made a rule, so they hired their cronies to run all the departments. Anyway, that's the reason -- the only black mark I find on him. He was very efficient.

in advance while he was there, but he didn't see far enough, as far as I was concerned.

CBP: Peter Tilley, D.O., became PCOM's fifth president in

1984.

HD: Right.

CBP: Please comment on his strengths and weaknesses as a leader and the highlights of his administration.

HD: Well, Pete Tilley was Chairman of Staff and I was assistant. I was going to be Chairman the following year -- would run for the following year -- when suddenly, of course, Tom Rowland died and they were looking for a new leader. We had Ginny Thompson around -- assistant to the President. That was a lot of politics in there, and he finally put Pete Tilley in charge. Well, Pete Tilley was kind of run by the administration. He was one of us. He's one of the D.O.s. We thought it was a good idea to have a D.O. in there. But it turned out he was not too much different than the guys who were in there ahead of him. He was basically going to do things his own way. At any rate, finances got worse and worse under his administration.

CBP: Why?

HD: [laughs] You see, unfortunately, he got me in a lot

of politics here. Why? That's a good question!

CBP: What was going on in the mid-1980s that was pressuring him?

HD: Well, there was a lot of talk -- oh, boy. Well, you know downsizing and all this other stuff was going on, and they were getting less money from the government. They got into this government deal, and now they got the HMOs, they talked all the doctors into that, and then they're cutting down on how much they're paying, and the state's not paying, and all this stuff, Blue Cross/Blue Shield is not paying, etc. Anyway, most of the revenues for the college were coming from the hospital. Well, when the revenue started going down from the hospital, PCO felt for money. Now, usually when somebody is , the problems, and I blame a lot of problems we had on the Pete Tilley administration. He was a good friend of mine, and I became Chief of Staff automatically when he became President, and I was Chairman of Staff for three years. But being Chairman of Staff, they put me on

the board for three years, so I got into the politics. And it got so bad, we thought they were running the thing so poorly, we got them ousted. One of the talk in those days was politically they try to run us down, and some other group was going to take over the hospital, and all that got mish-mashed, and finally we decided to change the Administration. That's when Lenny Finkelstein came in. , I took the opportunity to go around and get a petition and he got in power. Pete Tilley was able. He and Judge Hoffman and the Board -- disrepute, in other words. We decided we ought to change things. So that's when Lenny came to.

CBP: What do you mean by he and the Judge and the Board were in disrepute.

HD: [laughs] If you don't like the President, you try to get him out, don't you? Even the President of the United States, right? And we didn't like him, and we thought he ought to go out.

CBP: Why? What was it that you didn't like?

HD: We thought they were doing a poor job. They were running the place down.

CBP: What did you think at the time about Tilley's plan to sell the hospital?

HD: That's the irony of the whole situation. [laughs] He wanted to sell the hospital, and that was a big factor. You see, you're asking me a question and I can't answer in a few words. The fact that they wanted to sell the hospital was one of the major reasons we decided to . We didn't want to sell the hospital. We thought it was very important to keep the hospital.

CBP: How did you feel two years later, when Dr. Finkelstein sold it?

HD: I voted the first time not to sell the hospital, and the corporation -- there were like eight votes against selling, and I was one of them. I'm still against it. I think it's a mistake, and so forth. Now, money-wise, they can give you an argument. If you're a businessman you can say, "That's a good argument." They compare us to Harvard. Harvard

doesn't own a hospital. Now, how can you compare Harvard to us? That hospital was very vital to us. Now it was in power the Graduate Hospital over there. Our guys are the whole situation. You see, one of our greatest fears over there is they're going to sell that place, and some other group is going to take over as a medical school. That's what's going to happen.

CBP: When you say "our" greatest concern, who are you speaking for? As an alum?

HD: Yes.

CBP: That the college would no longer be PCO?

HD: Yes. As a corporation member, as an alumnus, professor emeritus. Can I go on? I've been in this business since I was a kid. My father and mother -- I can go back and tell you a lot of things about how these things started. They started right in my own house.

CBP: Do you know if the corporation has been approached with another medical school trying to buy it out?

HD: Well, that was the talk way back. There was always

rumors going on, you know? You see, one of the problems is Hoffman was also on the Board at Einstein, and that was the fear. It was going to be Einstein or somebody like that was going to take over. But nothing's changed except the new group came in, they bought Parkview, saying Parkview was a thing to itself, and then when Parkview didn't do well, three months later they were saying, "If Parkview doesn't make it, we're going down." We were lied to. A lot of lies in there.

CBP: Do you think there is an ongoing demand for PCO to remain an osteopathic college?

HD: Oh, yes. Sure, there's an ongoing demand, but they're going to be financial reasons and political reasons to do otherwise. The way things are going now -- the insurance companies are running the health care system. And it's only a step for them to run the medical schools. They are starting to run the medical schools, too. Just a step away to take over the medical schools, because where best can you control all this? Johnson -- ABC Director

of Medical -- did you hear him Sunday? -- Dr. Johnson -- give a speech at the graduation of PCOM?

CBP: No.

HD: Even he -- he's a very liberal-minded guy, and he even he says, "We're going to a one payor system." A one payor system. Do you know what that means?

CBP: One health care provider?

HD: That's right. And who do you think that's going to be? The government is going to be the one health care provider. So we're going to get the same place we were trying to stay away from before, and that was national medicine.

CBP: Socialized medicine?

HD: Socialized medicine. It definitely was going to be that. No question about it. When you talk about one party provider -- that's what it means. Because look what's happening here with HMO. The reason we're down is because of the changes being made in the system. Where the system was going before, we were flying high. Right now, they're controlling the money, and they're telling us what we can do and

what we can't do, so the business guys are saying, "Hey, you can't do this. You've got to do the other thing. So HMO, for example -- Blue Cross/Blue Shield is trying to sell me HMO. Now, why would Blue Cross/Blue Shield want to sell me HMO? I pay them three thousand dollars a year for Blue Cross/Blue Shield to over-top my Medicare. They want me to join the HMO, and I don't have to pay the three thousand. It's going to be for free. They told me it's for three. Then when you investigate, you find that the government is taking over, and they can make more money from the government than from the three thousand dollars I give them because the government is going to pay them eight hundred dollars a month, directly to the HMO. So I'm not going to be on Medicare anymore; I'm going to be in this HMO. You see, everything is going through this HMO, which is managed care. And managed care is going to cause hospitals to fold. The corporations -- they fire people. This is either good or bad, but it's the way it's going. So it's eventual. So

when I say we blamed the people who are running the place, I realize that the background is what I'm talking about.

CBP: It's for the system.

HD: Yes, yes. It's what's happening.

CBP: In the past, professional recognition posed an ongoing challenge for osteopaths. In what ways did you experience this struggle while a student and throughout your career?

HD: Well, first of all, you've got to understand, my father was sued for medicine and surgeon, and the way those trials went -- he won, but we practiced as taught -- that's what the law actually said -- as taught, for years. It was a consequence, and we were allowed to do this. The M.D.s tried to shut us down. So there was always a prejudice. Everybody who came into your practice said, "What's an osteopath?" Well, in my particular case, most of my practice I took over from my father, and they already knew what an osteopath was. They didn't have to ask what's the difference, and

you'd have to spend time explaining to everybody what the differences were for anything. A lot of the D.O.s felt bad because they couldn't get the staff in the hospital. Well, the did them one better by putting them all in the staff of the hospitals, as long as they were general practitioners. But they wouldn't let me be a general practitioner anyplace. Not do surgery. I'm trying to do surgery. They wouldn't let me do surgery. So we got a lot of prejudice that way. If I hadn't had friends to help me along, it would have been difficult. So politics and the fact that you're an osteopath versus an M.D. was very important.

CBP: In what way has PCOM strived to overcome prejudices?

HD: Oh, just by doing a good job, and showing people we do a better job.

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

HD: The whole medical profession. Is that what you're talking about?

CBP: Well, to the osteopathic profession or to the medical profession. As a school -- what has the school's greatest contribution been?

HD: Well, first of all, we graduate more students than anybody in the profession. In fact, we're up about maybe seventh in the country in numbers, so we've got a big group of people going out there from PCO. PCOM is recognized as the best osteopathic medical school in the country. There's no question about that. Everybody realizes that. Our interns and residents are accepted anywhere. That wouldn't be true if that wasn't a fact. Right now there's very little opposition to anything. If you're a D.O., it means the same thing -- or even better -- than being an M.D. So I think we've made great strides.

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

HD: Well, I think it's important that we maintain our individuality because it's like if we got swallowed up by the MNA, we'd be like a local garage getting

taken over by General Motors. We'd be a nothing. everything, and we'd be insignificant. I realize we're fighting a -- it looks like a hopeless cause, at this point. It looks like it's inevitable, and I've thought this for years. One time there was a big osteopathic push in the late '50s and '60s, to with the M.D.s. The troy was they'd give us all the . Well, they did the same thing to the people in California, and then screwed them. Once they took the D.O.s out and made them M.D.s, do you know what they did? They closed the osteopathic schools and said you couldn't practice as a D.O. in California, which was Constitutional Farm. So we didn't want to get into that mess, because that would have hurt the specialists especially, more than general practitioners. General practitioners were accepted in all the colleges and in all the hospitals -- our D.O.s. made it difficult for the specialists to maintain hospitals by taking our

work. A guy who lives in South Philly, and he knows he can only send it to City Line -- he'd rather go to St. Agnes or Methodist Row, and so forth. These guys are sending patients all over, and over half the general practitioners in Philadelphia are D.O.s in the area, so we've got a big pool over there. We never did get more than ten percent of our D.O.

sending work to us, anyway. So this has always worked against us, but in the same way that a monopoly takes over -- we're going to go to one system and one medical school situation. There's no competition! And for that reason, it's going to be

for the patients. And I think that's the important thing. For example, I hadn't practiced for five years now, since I had a heart attack. I stopped practicing heart surgery, and I'm a patient. I'm really worried, especially since I'm a patient. You're not going to get the same kind of care. Things are changing. And I think eventually someday, they'll come to the realization that they're making a mistake, and it will swing back

again, but I'm afraid I won't be here that long, because this is the way it's going. Just like these companies, they're taking over everything, making big, big companies. That's the way health care systems are going. I think it's important for us to maintain our individuality, if we can, for the patient. After all, that's what we're supposed to be doing -- taking care of patients. Everything else seems to be more important today than taking care of the patients.

CBP: Thank you.

HD: Amen. [laughs]

End of Interview

Index