1997

Fairman Denlinger Oral History

Philadelphia College of Osteopathic Medicine

INTERVIEW WITH FAIRMAN L. DENLINGER, D.O. (CLASS OF 1953)
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
March 4, 1997

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

DENLINGER:

CBP: Were you raised in Paradise, Pennsylvania, too?

FD:

CBP: Where do you currently reside -- your complete address, please.

FD:

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

FD: There was an osteopathic physician in Paradise by the name of Dr. Harry Frew, and I had been interested in alternative medical care ever since high school. I was a varsity basketball player with Paradise High School. My dad would take me for osteopathic treatments by Dr. Frew prior to the games.

CBP: Did you have a specific ailment or injury that

necessitated treatment?

FD: No, no. This was for general osteopathic technique and muscle energy techniques to increase body tone, decrease muscle tension and to correct osteopathic lesion. It was like a pre-game warm-up, as far as I was concerned. Dr. Frew was a D.O., graduate of Kirksville Osteopathic College, and he was the first osteopath in our immediate area. In fact, he may have been the first one in Lancaster County, Pennsylvania.

CBP: Did you go to him for all your medical care?

FD: Yes, I did.

CBP: Your whole family did?

FD: No. It took a while for my father and my mother to get to that stage, but eventually, they did. By the time I was discharged from the Army, he was our family doctor. Later my family had Dr. Leroy Lovelidge, a D.O. who took care of my mother when she had cancer surgery at Lancaster Osteopathic Hospital and until she died at age 48.

CBP: Was anybody in your family ever involved in the medical profession?

FD: No.

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

FD: I attended Franklin & Marshall College for one year prior to World War II, and then I finished my degree requirements after World War II, in 1949. I have a B.S. in biology.

CBP: Why did you select PCOM for your education?

FD: I selected PCOM but my primary interest was the osteopathic college in California. I had spent a lot of time in California when I was in the Service, and enjoyed the climate, etc. But my mother was very ill when the time came for applying, and PCOM was very close, so we decided to apply here. And, in fact, that was my only application.

CBP: What were the highlights of your educational experience at PCOM in the early 1950s -- courses, professors -- that might have made a significant impact upon you?

FD: Well, everybody who went to school at that time was

impressed with Angus Cathie, our anatomy professor. Every morning at eight o'clock, it was a quiz and answer time -- oral quiz and oral answers. That was a traumatic introduction to osteopathic medicine. He later became acting head of what was called the osteopathic manipulation department. At that time he taught us not in school, but in seminars and individual cases, various manipulation techniques. That was number one. Number two and three were the two men who were involved in the osteopathic medicine department, Dr. Nicholas Nicholas and Dr. David Heilig. I was very much interested in them, and I was active, as far as going to the various seminars they held. They had osteopathic professors coming in from other schools and speaking. That just quickened my interest. There are a number of other ones, also. Otterbein Dressler was head of pathology, but he was also the Dean. When I applied for the school, he was the man who interviewed me. He had a rating system for prospective students, and

he told me where I would be ranked in the class when I graduated. And he was wrong. [laughs]

CBP: He was wrong? Where did he have you?

FD: He had me in the middle of the class, and I graduated the top of my class. I later knew him in Detroit, where I took my residency in Obstetrics and Gynecology. He had moved to Detroit and was in the pathology department at Detroit Osteopathic Hospital, so we stayed in contact that way. He was a man who was interested in students, but he was also a "guider," or a true professor, as far as directing and teaching was concerned. There were very few professors at PCOM at that time from when I didn't derive something. I was not in any classes that I thought were a waste of time, however.

CBP: Was there a research component of your medical education?

FD: No, there wasn't at that time. We had several societies and fraternities. We had a fraternity which met every Friday evening in Phi Sigma Gamma

House. The D.O.s who practiced in the Philadelphia area, as well as the instructors at the school, would come down to the fraternity, and we would have an OMT session. They would teach us techniques, and why they worked and why some didn't work, and various injuries or reasons why we would use particular techniques. That's where we really learned osteopathic manipulation.

CBP: More so than in the classroom setting?

FD: Yes. We were there of our own free will, and we practiced techniques that had been taught in class. This was interesting to us because these were men in practice, who were making their living as osteopathic physicians. They weren't just professors, but they also were practicing D.O.s.

CBP: Please share your recollections of the 48th and Spruce Street building and neighborhood when you were a medical student.

FD: Oh, I have fond memories of that. I had just gotten out of the Service and had no money. I was able to

attend PCOM because of the G.I. Bill. I was married. We lived in a third-floor apartment on 48th and Springfield. My wife was teaching at Marple Newtown High School, and we only had one car. So she drove the car to work and I walked to 48th and Spruce. That was about eight blocks. That was never a problem. It was such a beautiful area at that time. The building was a remarkable piece of architecture. I wanted to be an osteopath, and this was where I wanted to be. It was a very enjoyable time for me. It was very hard, and we did a lot of work -- a lot of studying -- because of Angus Cathie and other difficult professors. But I'm very thankful for them because they made me study, more so than I would have -- I think it's natural that you tend to slide by on the easier courses. Maybe just a pass or fail grade. But when you're working for excellence, then I thought this was a great school to come to. I enjoyed the environment in the school and outside the school, as well. That was a

very enjoyable time in my life.

CBP: Was it hard coming back to being a student, after having been in the Service?

FD: No, because I had joined the Army Reserve Corps, and I knew I was going to be drafted anyway. But they had a program for college students. They would get basic training, and then be sent back to colleges to complete their education and go into medical school. But that turned out to be a misnomer because we were inducted, given basic training in the Medical Corps, and then sent to California where we became an Infantry Battalion. We were given basic infantry training because they thought we were going to go to the South Pacific. But, as the Army usually does, we were sent to Europe. We went to Ireland and England before the invasion took place. That was my whole purpose -- to get out alive, and back to medical school -- osteopathic medical school.

CBP: Did you do anything medically related while you were in the Service?

FD: No, other than the basic training. We were trained to be corpsmen.

CBP: How to be medical corpsmen?

FD: Medical corpsmen -- right. The Army Camp at Joseph T. Robinson in my favorite town, Little Rock, Arkansas. We hiked over the Ozarks. For whatever reason, I was selected as cadre, which meant when my group got through, I would stay as one of the trainers for the next group. Then after that group got through, that was the last time there was any such training at Camp Robinson. And that's when we were sent to California to join another group, which was primarily going to the South Pacific. Once we got to California, that was my end of medical training, as far as the Army was concerned. I was in the Infantry until I got discharged.

CBP: Please describe the clinical training you received in the 48th Street Clinic.

FD: Well, the clinics were held at two places. They were held in the basement of the school at 48th and

Spruce. And then in my senior year, there was a clinic at the Women's Hospital I believe it was, at 20th and Susquehanna called "North Center" -- we enjoyed that. In fact, they had operating rooms in that building at that time, and we assisted as much as we could in that training. But also, there were outpatient clinics there, and we enjoyed these clinics. The clinics at 48th Street were the biggest clinics, and that was a very thriving clinic with many local people, as well as people from some distance -- not beyond Philadelphia, but areas around Philadelphia -- coming for treatment.

CBP: How would you characterize the difference between your experience in the 48th Street Clinic and your experience in the 20th Street Clinic?

FD: Well, as far as the clinical experience, 48th Street Clinic was the biggest one and had more patients. The emergency room at Women's Medical had been closed, so we did not have many walk-in patients. Our day, when we were on the clinic service would

amount to seeing maybe one or two patients. But they also had surgical rotations, and I remember scrubbing as a surgical assistant my fourth year at 20th Street. But the volume was not what it was at 48th Street. It was a changing neighborhood. My first experience was driving through a gate. The whole 20th Street Clinic was in what we would call a compound. There were walls around it, and you had to have some kind of identity to get in and out. But I remember we never liked working there because there were a lot of ex-G.I.s in the class, and we had families, and the drive over and back was very time-consuming.

CBP: Did you have any more or less responsibility at either clinic?

FD: Oh, I think we had for more responsibility at 48th Street. We saw more patients and we had our regular booth where we saw patients. We were able to diagnosis and treat under supervision of the clinic supervisors. Some of the specialists would come for

specialty clinics, and we would refer our patients to them for additional diagnosis and treatment.

CBP: Who was Director of Clinics while you were a medical student?

FD: I can remember who was in charge when we were in the hospital. I can remember who the student physician was. It was Dr. Nick Tretta. I can't recall who was in charge of the clinics at 48th Street.

CBP: As a medical student, to what extent were you involved with patient care in the 48th Street hospital, other than in the clinic?

FD: In the hospital, we were responsible for the history and physicals. But more than that, we had an OMT service, with Dr. Barbara Redding. We had patients assigned to us to whom we gave osteopathic treatments. There was one particular treatment every four hours. Others would be twice a day. And there were some that did not get any osteopathic treatments, such as the extreme surgical patients. Especially orthopedic patients. We didn't give any

osteopathic treatments to them. Dr. Redding was our direct supervisor, and she was there all the time. We had definite patient assignments as well as regular teaching sessions. There was a surgical amphitheater, and we were allowed to go there and watch surgery from the balconies. I did scrub on some surgeries when I was a senior. The best experience was making rounds and attending physicians who would discuss their patients with us.

CBP: What surgeons do you remember scrubbing in with?

FD: Dr. Street.

CBP: Carlton Street?

FD: I don't remember his first name. I believe he was an M.D. who taught in the school. I'm not sure whether he was a D.O. who then got his M.D. degree and then did his surgery in the PCO Hospital. But I know we scrubbed with him. Of course, Dr. Galen Young, a fine osteopathic surgeon. We attended OB patients in labor, monitored their labor and occasionally scrubbed with them. Either we scrubbed

at the time of the delivery, or worked at times as the surgical scrub nurse, as the instrument nurse and whatever the physician needed at that time. When there was no intern present, then we were the first assistant, as far as deliveries were concerned.

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

FD: Yes, we did home deliveries. I did home deliveries. They were done without supervision. There was a supervisor on-call, and we could call him at any time if we had problems, but we went out by pairs. I remember we were going to South Philadelphia for home deliveries. We went to the first public housing in Philadelphia. We did home deliveries in that area, also, and wherever we went, they knew that we were osteopathic students. Of course, we had our bag and we had our name tags and everything.

We were widely accepted, and that was a great experience.

CBP: Were these deliveries completely without any kind of anesthesia or analgesia?

FD: Yes. We couldn't administer anesthesia and we couldn't give any drugs. We were not yet licensed. But they were home deliveries. [laughs]

CBP: [laughs] Stronger women than I.

FD: It's interesting because when I finished my internship, I went into general practice in the little town of Strasburg, Pennsylvania in the Amish County where I did a lot of home deliveries. I was thankful for the training I had at PCOM and home deliveries. Oh, one other thing. Pediatrics -- yes. We would make house calls on the kids. I remember giving my first shot of penicillin. The mother had on a dark blouse and I put the child across my lap to give the penicillin. When I gave the shot of penicillin, the needle and the syringe were not one unit, the needle came loose at the

syringe attachment, and the penicillin sprayed over the room, over me, and I looked up, and over at the mother with her dark blouse. There were white spots of penicillin all over it. [laughs] So that was my first experience with giving an injection of penicillin.

CBP: Did that child let you near him again? [laughs]

FD: Yes, he did. [laughs] I gave him a second shot. I made sure he got that one all right. Yes. [laughs]

CBP: Do you recall an OB clinic at 3rd and Lehigh, or having heard about one there?

FD: I don't think so. I don't think we went to that. I don't think that was one.

CBP: It might have been before your time, but I'm wondering if you ever heard about it.

FD: No, no. If we did, I certainly don't recall it.

CBP: Do you recall a clinic near the airport vicinity?

FD: No, we didn't go there.

CBP: Did you receive any training at Metropolitan Hospital?

FD: No. Metropolitan was developed while I was in school, while I was still a student. I think that's right.

CBP: Well, it started around 1945.

FD: Okay. Then, no. No, we never went down there.

CBP: As a medical student, how much responsibility were you given during deliveries, other than when you went out to the people's homes and did it all by yourself?

FD: Very little, because they were all private patients that came to 48th Street Hospital. If there was a clinic patient, the OB resident would be doing the delivery. We sat with the patients and timed contractions. Rarely we were permitted to do rectal exams to determine the progress of labor -- sometimes just eight hours of timing and recording each contraction. At that time most of the deliveries were done under caudal anesthesia, and caudal was the reason people came for their deliveries.

CBP: Well, then, how did you learn enough to go out to do home deliveries unsupervised? [laughs] What if you had a breech presentation when you were out doing a home delivery?

FD: Well, breech presentations were delivered vaginally in those days. It's only been in the latter part of my experience that all breeches had cesarean sections. I was trained during my internship in Lancaster Osteopathic for home deliveries. There were a number of physicians, especially one -- Dr. Yeuninger who did a lot of home deliveries. His successor, Dr. Whitlow Show, was also doing home deliveries. I learned some from the deliveries that we did here, at PCOM, but 90% of my obstetrics was learned during my internship at Lancaster Osteopathic Hospital. And then those doctors doing home deliveries would hold intern sessions almost every week, and would go through their experiences and teach us about doing home deliveries.

CBP: What was the nature of faculty/student relationships

when you were a student in the 1950s?

FD: Well, the relationship is entirely different than it has been since I returned to PCOM, and then subsequently retired. We did not have the relationships that the present-day students had. This was a professor/student relationship that we had. We may have had advisors at that time -- student advisors -- but I'm not aware of it. I guess the man that I could go talk to as a faculty advisor was Dr. Bradford. In fact, his office was at 20th and Allegheny. My wife was having some problems, so we would ride the trolley car and then the subway and get off at 20th Street, and walk maybe four or five blocks to his office, and he would treat my wife with osteopathic manipulation at that time. Later, there was a strep throat epidemic in Philadelphia, and both of us -- my wife and I were ill. Dr. Bradford made a house call and saw both of us in our apartment at 48th Street. My class did not have a good relationship with the

school when we graduated. I don't know why -- whether it was because practically all of us were veterans. But my class -- and it is the only class I can talk about -- and the faculty did not get along together at all. In fact, when I graduated, I came back after graduation and went to thank the anatomy professor at that time. He knew me and he received it, but he said, "Yes, your class really gave me a bad time." So generally when we left here, we had a poor opinion of the school. Not for the training, but I think the relationship between professor and student. It was not the warm relationship which I see now and was involved with before I retired. I often think about that relationship because I never had the feeling for PCOM that the present day students have. I remember my training, and I think of it fondly because this is what I wanted to do. Only a few of us contributed financially after our graduation. Our class was probably the poorest or one of the poorest

for the last fifty years regarding alumni giving. [laughs]

CBP: Do you have any sense of what percentage of your class consisted of G.I.s?

FD: I think it was almost ninety percent. There were ninety-four in my class, and I think there were only maybe ten or twelve who were not G.I.s.

CBP: What were the highlights of your social experience at PCOM and in Philadelphia while you were a student?

FD: Oh, social was always the graduation dinner.

CBP: Where was that held?

FD: It was in the Bellevue Stratford. That was a highlight because we all wore tuxes and our wives or girlfriends wore evening gowns and corsages. That was the big deal. The fraternity had parties, but we didn't attend these very much. My wife was working and I was an ex-G.I., bent on graduating from this place. My wife and I didn't have much of a social life because I studied and she prepared her

lesson assignments for teaching the next day in high school in Marple/Newtown. Of course, the graduation itself was held in Irvine Auditorium. I think Irvine Auditorium belonged to the University of Pennsylvania. That was the highlight of the whole thing, that I can remember more than other things. I can remember other incidents that happened, but the social life was not large at all. I can't remember any student council activities. There may have been. I was President of the student council the last year. We may have had a student council dinner dance. But other than that, there were few social activities. Of course, the welcoming freshman dinner. Dr. Dressler, the Dean, had a catered dinner for students as well as all the spouses in the school auditorium. Obviously, that was the first time we had exposure to PCOM. That was a great thing because a lot of us were married and the spouses did not know much about osteopathy. My wife was from the same town that I grew up in.

Her family went to M.D.s in the town and in the area. Dr. Dressler would always talk to the spouses about what their spouses were going to go through, and he was gung-ho for osteopathic medicine. I remember when we came home that night and my wife said, "This is where you belong." Prior to this time -- prior to my coming here -- the people that knew me wanted to know why I didn't go to a medical school or why I didn't go to Jeff. In fact, the professor of biology at Franklin & Marshall was my student advisor and pre-med advisor, also. He always had an unlit cigar which he would use as a pointer. When he found out that I applied to come to PCOM and was accepted he said, "Denlinger, I don't know what's wrong with you. Don't you want to be a real doctor?" I said, "Yes, Dr. Foster, but I want to be an osteopathic physician." He'd say, "Well, I think you're making a bad mistake. I can get you in at so-and-so medical school." I said, "No, I'm not interested. This is the only place I

applied. That's what I want to do." He said, "Well, Denlinger, I don't know. I'll see you later, after you graduate." And it's interesting because his son was in my class in pre-med, in biology class and he became a dentist.

CBP: Were there any neighborhood restaurants or coffee shops or bars that were a meeting place for the students?

FD: Yes, I don't remember the place, but it was right across the street at 48th Street. That was always it for those of us who didn't carry a lunch -- a lot of us did not. My group carried our lunches because we couldn't afford to buy meals. [laughs] What was that called? There was a cafeteria on 48th Street -- west on Spruce. It was within the first or second block, beyond the school. We would go there occasionally. I learned to play bridge during my freshman year at PCOM during our lunch hour break.

CBP: You mentioned that you belonged to Phi Sigma Gamma fraternity.

FD: Yes.

CBP: Could you please describe the activities of the fraternities in the 1950s?

FD: Well, the activities that I attended were certainly the Friday night session. That was the session where we really learned osteopathic manipulation. There were other activities as far as fraternities were concerned, but I was not a fraternity person. I attended the meetings that I had to, and paid the dues. But some of the fraternities were still back in the good old college days. Rather than being professional fraternities.

CBP: When and why do you think fraternities started to wane at PCOM?

FD: I don't know when they waned because I was away from PCOM for five years, as a G.P., then three years in Detroit, and then twelve years in Chicago at the Chicago college. When Dr. Rowland became President, he invited me back here. So I had lost any relationship with fraternities during that period of

time. I was surprised when I came back that there was hardly any fraternity activity. Hardly any activity as far as professors were concerned. I think they started to decline my last year at PCO. There were a couple instances that happened in fraternities that the administration found out about and was not pleased with at all.

CBP: Could you give me a for instance?

FD: No. [laughs] There were unacceptable activities.

CBP: I understand you were a high school basketball player. You talked about that a little bit.

FD: Yes.

CBP: Were you involved in athletics at PCOM?

FD: No.

CBP: What type of athletics and other recreation were available to students in the early 1950s?

FD: There was a basketball team organized here, but I think that was organized by the students. I don't recall any other organized athletics at that time.

CBP: Do you recall still having privileges at the Y at

52nd and Sansom?

FD: Yes. I played with the basketball team several times. I'm not sure where we played, because I only played with the team once or twice.

CBP: We've spoken a bit about the experiences of coming through on the G.I. Bill.

FD: Yes.

CBP: Is there anything else you'd like to comment about how that affected your experiences at PCOM -- you and your classmates?

FD: I guess the word I want to use is 'mature.' We were mature people. We had lived through a war, and some of us had very bad experiences. I think most of us, when we got out of the Service, knew what we wanted to do and what we didn't want to do. I can say this about the G.I. Bill. If it weren't for the G.I. Bill and my working wife, I'd never have been at PCOM.

CBP: How much was tuition back then?

FD: First time -- first semester it was four hundred and

fifty dollars. We got fifty dollars spending money from the G.I. Bill. [laughs] That only lasted about a semester or two. Then tuition went up to five hundred dollars. I don't think it was any more than that when I graduated. The G.I. Bill covered $500. If it had been more than that, I don't know how we could have made it because we were living on my wife's salary as a teacher. There were a lot of ex-G.I.s attending, and it was due to the G.I. Bill that they were able to get through PCO.

CBP: If the G.I.s were filling up the spots in the class, what happened to the men or women coming out of college at that point who were not G.I.s, who would have been in the normal pattern of things, applying for graduate school or professional school at that time?

FD: I don't think it made any difference that you were a G.I. because the competition was so great at this time. All of us who got in at that time got in because of our college grades, not because of the

G.I. Bill.

CBP: I'm not suggesting that. I'm just trying to say that it seems like there might be a back-log of perspective students waiting to start medical school.

FD: No, because most of us had not finished our undergraduate education. I got out of the Army in 1946 and it was not until 1949 that I matriculated here at PCOM. And osteopathy wasn't as popular as it is now. The medical schools had small classes -- 100 to 120 in freshman classes. This was an era when only a small percentage attended college and fewer still applied to medical school. I sat on the Admissions Committee for a number of years, and I know the number of applicants which we have far exceed our class applications. I don't know how many were here the year I matriculated, but ninety-four in the class accepted. I don't know how many rejects there were. The G.I. Bill not only covered college training, but it would cover other things.

Trade schools and things like this. So it didn't always cover just straight medical schools. If it had any relationship, I wasn't aware of what the relationship was. I didn't get here because I had the G.I. Bill. I know that because I knew who the Dean was. [laughs] And he wouldn't have allowed that.

CBP: I'd like to talk a little bit now about specialization and practice. When did OB/GYN develop into a specialty within osteopathy?

FD: I believe it was during the time that I was a student. There were very few surgeons in the osteopathic profession at that time, so there was no GYN surgery. That was all done by the general surgeons. I know that may have happened before I got here. It was started as a college of obstetrics, as a specialty. Then it developed. It was only maybe around 1958 or 1959 that that training for OB/GYN included GYN surgery. If you wished to do GYN surgery before that, you had to

have an extra year or two under general surgery. I know when I did my OB training in Detroit, there was no GYN surgical training. When I was on surgery service, a couple of the heads of groups of surgeons wanted me to stay on for the extra year and get GYN training, and I wasn't interested in that.

CBP: When did the OB/GYN residency start within the osteopathic profession?

FD: I don't know. I know there was an OB/GYN resident here when I started -- by the time I was a senior. But when it formally started -- I would have to research that.

CBP: Could you outline the significant developments in the OB/GYN training for undergraduate medical students as you've seen it change over time?

FD: Oh, yes. The teaching is much better. It's no longer just anatomy, physiology and chemistry being the big three. It is now an important course in the curriculum of the colleges. And then the training programs became more sophisticated and more

involved. The training at the student level is much further advanced. Other significant trends are the participation by students in OB/GYN clinics in the various clinics and hospitals, whether DO or MD, away from PCOM and in the clinics and doctors' office on the PCOM campus. Further, there is a greater emphasis on student participation and learning, especially with the required reading and the presentation of papers in seminars. And there is a greater emphasis by the dedicated faculty on graduating a student capable of taking his or her place in society and cntrbuting to that society.

CBP: Can you pinpoint approximately when that shift would have been, to better OB/GYN teaching?

FD: The day I graduated from here. [laughs] Don't publish this. We felt that that was the poorest course there was here at PCOM -- the OB/GYN course.

CBP: From 1974 to 1982, you served as PCOM's first whole-time Chairman of OB/GYN

FD: Yes.

CBP: How was the leadership of the department structured prior to your position?

FD: Well, that's when I came back from Chicago -- in 1974. At that time, I think Dr. Gruber was still head of the department. Dr. William Morris was working in the department. He was the only whole-time faculty member. The other men -- if they did deliveries, were all in private practice. Bill Morris was hired by the institution to do deliveries during the day. There was another physician working as a night hospital physician. He covered the few clinic deliveries. The number of deliveries was very low. The OB department was very low when I came here.

CBP: I guess I'm still not clear, as far as an answer to the question. You were the first whole-time Chairman.

FD: Right.

CBP: The person that preceded you was Dr. Gruber?

FD: Yes, I believe so.

CBP: So you did not have private practice when you were Chairman?

FD: No.

CBP: Were you practicing within the clinic?

FD: Yes, in the clinic. And I would have "private patients" who saw me here, and I would do their deliveries, but the money went to the institution.

CBP: But you were basically full-time, committed to being on the campus?

FD: Yes, I was.

CBP: On the premises?

FD: Yes. We had out-patient clinics. We had one over in Roxborough. And PCOM still had some out-patient -- the building down at 48th Street -- there were still some OB/GYN clinics down there.

CBP: I read somewhere that under your leadership, PCOM had its first OB/GYN resident, Gerard Szczygiel, who graduated in 1972.

FD: That's correct.

CBP: Was this in 1974? Did this start right up when you

came?

FD: Yes. There were no residents here when I came. When I was here for my final interview before I accepted the job and they accepted me, they told me that Dr. Szczygiel was interested in obstetrics, and he was doing general surgery at the time. If I came, he would switch over -- he would complete his surgery and then shift over to OB.

CBP: What was the nature of graduate education in OB/GYN, if any, prior to that residency program, starting in 1974?

FD: I think there was very little.

CBP: Please describe the residency program and the changes it's undergone since 1974 -- both in the way it expanded, the number of positions and then also qualitatively, what has been put into the program to enrich it.

[end of side one]

FD: When we started, as we said before, Dr. Szczygiel was the first resident. The number of deliveries was very low at that time. So the concentration in my early years here was to build-up the number of deliveries, which mean going to clinics in the clinics over at Roxborough and down on 48th Street. And then also in the first floor of the PCOM hospital -- became out-patient offices for the men who were whole-time physicians there. Dr. Dieterle and myself and Dr. William Dickerson and Dr. Caruso. There was a surgery office. There was an office for general medicine. And then the specialty groups, too. We had OB clinics here and GYN clinics. It was split into both. And at that time, the patients were few and far between. It amounted to building it up, and it was actually physical work, in which we did everything. We took care of the patients who came in from the emergency room. Dr. Szczygiel, being the only OB resident, was with us as much as he could physically hold up. At first it was just

Dr. Morris and myself, to cover the deliveries and to cover the emergency room. Then Dr. Fliegelman joined the Department, and added a lot as far as the student teaching program was concerned. And also as far as the residency program was concerned. He was a GYN surgeon.

CBP: Could you be more specific in telling me what did Dr. Fliegelman add to the program?

FD: Well, he's a good OB/GYN physician, and he was a great teacher for the students. But he was also a great teacher and instructor, as far as the residency was concerned, because he was GYN surgeon and I'm not. I'm an OB surgeon. He would do some of the GYN surgery there, and that was a great help. We would have sessions, not only for Dr. Szczygiel, but also the interns and externs who were here. We would have that at least once a week, in which we had formal sessions and formal presentations and formal topics, and trying to teach Dr. Szczygiel that we felt he should know as an OB/GYN person.

CBP: When did the residency program expand to be more than just Dr. Szczygiel?

FD: I think it expanded after he graduated.

CBP: How many years did he do his residency?

FD: He did three, and the year of surgery was acceptable at that time by the OB/GYN college.

CBP: So that brings you up to around 1977.

FD: Yes.

CBP: And then how many did you have?

FD: Then we had two. We had Bochetti and Rick Turner.

CBP: How big did the residency program eventually get?

FD: I don't know now. It got bigger after I left. It couldn't expand before was because the number of deliveries AOA felt was not enough for any expansion. I think it was when Dr. Mancy was here and then Dr. Abbott came, and we still only had two residents at that time.

CBP: What years are you up to right now?

FD: About 1979 or 1980.

CBP: How about by the time you completed your position as

Chairman, which was 1982. How many residents were there per year at that point?

FD: Two.

CBP: PCOM's clinics have always been an important part of medical education and patient care. When you came back to PCOM in 1974 as Chairman of the Department, how was the 48th Street OB/GYN clinic different from the time you were a medical student in the 1950s?

FD: The volume was much lower because the school campus was out here, and the building at 48th Street was only held in clinics in the basement or the first floor. The building had become worn-out and the facilities were not kept up-to-date. The neighborhood had changed, and there were some patients coming in for OB and GYN clinics, but there were very few OB patients because they had to come up to this campus at City Line for their deliveries, and most of them didn't want to come that far. All the GYN was strictly out-patient GYN, with very few in number.

CBP: Was there at any point, an OB/GYN clinic here, at City Avenue?

FD: Yes, there was.

CBP: While the one was still open at 48th Street?

FD: Yes. Because until that was developed on the first floor, I saw patients on the OB floor of PCOM Hospital in my office.

CBP: Are you speaking of City Avenue?

FD: Yes. There were a few OB patients that were sent up from 48th Street to see me in the office at City Avenue. I guess that may have been a year until we moved down to offices on the first floor -- the ground floor in the hospital. Then, at that same time, we began to hold regularly scheduled OB/GYN clinics. There were still private patients seen, but everything was scheduled by then. That may have been two years after I was there.

CBP: Could you describe the clinics in the City Avenue Hospital? We've talked about them at 20th Street and we've talked about them at 48th Street. Could

you describe the clinics at City Avenue -- both the physical location and set-up and the ways in which it might have been operated differently from 48th Street, if, in fact, it was.

FD: Well, the facilities at 48th Street when I was there were in the basement, but it was a large area. There were booths and a large waiting area and a large reception area and a large desk and the building was excellent. There were at least three or four people at the desk. Down here, when we started at City Avenue, we only had two offices at that time. We would see patients in the afternoon at those two offices. And that was almost like a private practice.

CBP: So the volume was very different then, than it had been at 48th Street.

FD: Oh, definitely so.

CBP: Does that have anything to do with Medicare providing payment for visits to private patients instead of patients having to go to the free

clinics?

FD: We saw only OBs and a few Medicare GYN patients. The Medicaid paid a minimal amount, and if the hospital were going to survive, they had to have paying patients. They had to have insurance-covered patients for private care.

CBP: But how did the change in health care insurance or Medicaid affect clinic operations? I mean, you used to have all these free patients who could get some money.

FD: It never changed as far as I was concerned.

CBP: No?

FD: No. I didn't know. I saw patients and I took care of patients. My livelihood didn't depend on having a private practice, so I could take care of as many as was physically able to.

CBP: But why did the clinic practice fall off so much at City Avenue, to the extent that you're saying there were just two offices for the clinics?

FD: Well, there never were more than two offices.

CBP: For the OB clinic or for the entire clinic?

FD: No, I can only speak for the OB clinic. Because prior to that time -- this was the first year -- PCOM had not had whole-time faculty, and Dr. Dickerson and I came the same time. Dickerson was chairman of the Medicine Department, and we needed a place to see patients. There was no place to see a patient. So they converted the first floor. That whole section was converted into private offices. Private being that there were those of us who were employed by the institution were seeing clinic patients as well as private patients. It didn't make any difference. So as far as that is concerned, I think it increased. There was simply the volume. And then when this building opened -- when 4190 opened -- then we had many more rooms, and we had large a clinic practice. There was more clinic than there was private.

CBP: To what extent do you think your patient community changed with the move to City Avenue?

FD: I don't think it changed that much. We had non-paying patients, we had full coverage patients, as far as insurance is concerned. We had cash patients.

CBP: But were they the same patients? I'm not asking the question, "How did they pay?" If Joe Smith was your patient at 48th Street, did Joe Smith then travel to City Avenue just to see you, or did you get a different community coming in?

FD: Some people came here from this area -- yes -- from the West Philadelphia area. But I didn't see many people at 48th Street when I came back. The clinics were very low as far as attendance was concerned. It didn't change us. It may have changed in the locale. They may have come that were closer to the hospital, but I know that some people took two busses to get to our clinic. I was reminded of that one time. A patient was two hours late. You were supposed to be here at so-and-so. "Oh, Dr. Denlinger, it took me two hours. It took me two

busses. I take this bus to here, then I have to wait for this bus to get out here. That's why it takes so long." But we had patients who travelled. We had patients that came from South Philly or Southwest Philadelphia. But it was mostly public transportation that they had to use.

CBP: When Dr. Barth identified the City Avenue site, there was a vision that it would be a gateway to the eastern mainline suburbs, as well as still being on the border of West Philadelphia.

FD: Right.

CBP: Do you think that that gateway was ever realized?

FD: No.

CBP: I wanted to talk for a minute about OB/GYN clinics in satellite health care centers. We've already talked about 48th Street having maintained an OB/GYN clinic, even when the institution moved to City Avenue. North Center Hospital, I believe, you said had an OB/GYN clinic there.

FD: Yes. North Center.

CBP: And then that became Cambria Street around 1976, I believe it was. Was there an OB/GYN clinic that has been in Cambria Street?

FD: Yes. The residents went there, and I would go there occasionally. I usually went to Roxborough Clinic.

CBP: That was my next question. Roxborough did have one, then.

FD: Yes.

CBP: How about Laporte, out in Sullivan County? Was there an OB/GYN clinic there?

FD: Not that I know of -- no. At least none of us ever went out there.

CBP: Would the general practitioners have taken care of OB/GYN patients out there?

FD: I would think so.

CBP: What role do the clinics play in bringing deliveries into the City Avenue Hospital?

FD: Oh, I think they play a big role. I think that the clinics are feeders for this. The clinics are feeders for teaching hospitals. But primarily, it

would have to be for PCOM.

CBP: Did that change at all when the Hospital moved to City Avenue? Were the clinics as successful a resource for getting deliveries into the Hospital?

FD: Eventually, yes. Not right away.

CBP: Were people resistant to coming to City Avenue?

FD: Yes. When they would send a patient in, they didn't know whether there would be anybody here to see them or not. And then, I guess, the number of deliveries had fallen down because there wasn't adequate coverage. Whereas in the days of 48th Street, I know the men on staff rotated. They rotated coverage, and they came in for the deliveries. It wasn't leaving it up to the residents or leaving it up to the interns to deliver the patients. There was actually supervision all the time.

CBP: In 1946 -- and I know this is before your time -- there was considerable internal publicity about Julian L. Mines, III, D.O., from the Class of 1935, for introducing caudal anesthesia to the osteopathic

profession.

FD: Yes.

CBP: In retrospect, is Dr. Mines considered to be a pioneering figure?

FD: Oh, yes. Oh, yes. I don't know about the other osteopathic institutions. But as far as this place is concerned, sure. He started caudal anesthesia here, and then Detroit City Hospital developed epidural anesthesia, which was not too different from epidural. They did some epidural when I was here, but they were more adept at caudal anesthesia.

CBP: That was 1946, that Mines was introducing that here.

FD: I didn't know when.

CBP: How did that compare to the introduction of caudal analgesia into the obstetrical care, not exclusively here, but look at the entire medical profession -- allopathic and osteopathic? Was it cutting edge, was it five years after the allopaths were doing it? Was it the same time?

FD: No, that was cutting edge here. As one pathologist

said to me, "Well, I didn't think obstetrics was a disease. I always thought that was such a natural course that disease wasn't involved with it." And I think most of the obstetrics was local anesthesia in places, or spinal anesthesia. It took a while for caudal to get accepted. The old wives' tale that you don't want anything in your back was very prevalent at that time. Obstetrics has come a full gamut, and it's going the other way now because when I came back, the gamut was natural childbirth. Anything else was wrong. Now it's going back again, where ladies want anesthesia for their children. But, yes. Mines was on the cutting edge.

CBP: In 1977 you established a high-risk pregnancy clinic at the City Avenue Hospital.

FD: Yes. Right.

CBP: Please describe this clinic and comment on where this clinic fit in within the context of high risk pregnancy care in the osteopathic profession and the allopathic profession -- some perspective of how

cutting edge was to establish a high risk obstetrical clinic here.

FD: Well, the more OB you see, the more you realize that there are complications with it. And the whole idea of the high risk clinic was to identify these possible problems early in the pregnancy and train people and physicians and patients, as well. I had taken a number of courses and seminars in high risk pregnancies. Then there was the advent of the mechanical fetal monitoring. Fetal monitoring was not new, but the way it's done now is. I took allopathic seminars that were given. I got it from the group in Park Lane, Texas, the big -- I guess it's a public hospital, for lack of a better word.

CBP: Then was this, then, about the same time that high risk OB was being introduced to hospitals?

FD: Yes.

CBP: Are there any other ways in which PCOM was a pioneer in a specialty of OB/GYN?

FD: No, I don't think so. My training was in a D.O.

hospital in Detroit. My love is OB -- not GYN. I wanted to know all I could possibly know about OB, so that's why I always chose seminars that dealt with OB. At the same time, there were men from the other osteopathic institutions -- teaching institutions -- that were at these seminars, too. I think all of us who were in the OB profession wanted to. I did home deliveries for five years in the Amish county, and when there were any difficulties, where I had to take the patient to the hospital and the surgeons took care of the problems, and I wanted training in what I consider high risk. Not only to do normal deliveries, but to be able to care for the diabetic mother and the previous C-Section, and breech. I would get a breech for delivery, I still did vaginal breech deliveries. But that has gone by the wayside -- vaginal breech deliveries, and I'm not sure that's correct.

CBP: Well, the C-Section rates are so high. It's like twenty or twenty-five percent.

FD: It was here at one time.

CBP: It was twenty-five percent?

FD: After I left -- yes. Because nobody was delivering breeches vaginally or other high-risk pregnancies. The other cutting edge I think is osteopathic manipulation.

CBP: For OB care?

FD: For OB. Oh, yes. When I was here, I insisted that all the residents and the interns treated all the patients osteopathically. Now, there are some contraindications where osteopathic manipulation is not given. But everybody else got general osteopathic treatment.

CBP: Was that part of the prenatal care or during delivery?

FD: Oh, yes. Prenatal care, during labor and post-partum.

CBP: What do you consider to be your greatest accomplishment as a practitioner or teacher?

FD: I think during a time when I was Chairman of the

Corporate Health Department, when Drs. England and Rowland asked me to do this, I wanted the students to know what an osteopathic physician was, and the students learned -- in my office at that time, when they came in -- if they came in for whatever complaint. If they came in for a cold, they got a treatment. If they came in for strep throat, they got an osteopathic treatment. I think my greatest accomplishment -- my greatest satisfaction -- was being able to show osteopathic students the role that osteopathic manipulation plays in the treatment and the care of patients. As Bernadette, Donna Jamison and Sherisse Hatcher will tell you, we had a lot of patients. They all worked with me in the Corporate Health Office.

CBP: Could you tell me a little bit more about the Corporate Health service?

FD: Yes, it was a service that was developed for two purposes. One was to take care of injuries on the job and to treat sicknesses on the job for

employees. And also for the care of the students. I was the GP for the students. The other people -- I treated them also, or would send them home, and decide also when they had to go home, or if we could treat them here, we'd do that. We took care of a lot of our corporate people.

CBP: Which other OB/GYNs at PCOM warrant recognition for their contributions as teachers and/or practitioners, if you had to highlight any of your colleagues that came before or after you, or worked with you?

FD: Well, Dr. Eisenberg. He was a challenge for me. I wanted to learn obstetrics, and he made me learn obstetrics as a teacher. Dr. Fliegelman is here now as an educator. Bill Morris who was here -- because of his care of patients and his interest in the students. I think Dr. Mansi, when he was here. When he was here it was great for the students and great for the interns, also. I think he was a great teacher and GYN surgeon. One other thing. The

department that really helped me, as far as being an obstetrician was concerned, was the OPP Department, which was Dr. Nicholas Nicholas and his son, Alex and Dr. David Heilig. I worked in that department the last several years, one day a week. Their goal was not only to teach the students, but also to get the practising physicians involved with manipulation. Before I went to work one day a week or whatever, he would have me come over and lecture to the students, and show the students how we treated obstetrical patients, what were the contraindications for it, and what were the indications for it, and why did you do it this way. Those three men were very influential with students, and certainly with me, as far as the role of manipulation and OB is concerned.

CBP: How would you characterize the trend in OB/GYN, as far as the use of OMT? And do you think that OB/GYNs are using it as much as people did ten or fifteen years ago?

FD: No.

CBP: Do you think they're making a comeback or falling off?

FD: I can only tell as far as I worked here. No.

CBP: Do you think it's fallen off?

FD: Yes.

CBP: Other than the use of OMT, do you think that osteopathic OB/GYNs approach practice differently than allopathic OB/GYNs?

FD: Now? No. And I can only speak from this place. The other places I worked -- the OB Department Chairman gave osteopathic treatments, and in fact, I would go to them and get osteopathic manipulation.

CBP: Why do you think it's falling off here?

FD: I think physicians have become too busy. Volume cuts down osteopathic manipulation. Giving an osteopathic treatment takes time. In addition to seeing the patient, diagnosing the patient and follow-up care to the patient, it still takes time. You can't see ten or twelve people an hour. It's

"easier to give them a pill than it is to give a treatment."

CBP: From 1974 until 1982, you chaired the Curriculum Committee.

FD: No, not completely. My guess is maybe 1978 or 1979. But you're right. I was Chairman for a number of years when I first came here.

CBP: What I'm trying to find out is if you can recall any significant developments in the curriculum or changes in the way the curriculum was set-up here, during that timeframe.

FD: Yes, there has been much change. The object at that time was to make sure all the classes were met and with the development of a whole-time faculty, the teaching was excellent and all classes met. There were seminars for the physicians teaching or students in the various clinics. The education that's going on here now is fantastic.

CBP: Since that time, or during that time?

FD: Both during that time and since that time.

CBP: So it did expand.

FD: Yes. And it has continued to expand. The whole school itself has continued to expand.

CBP: Any specifics about that expansion in the 1970s?

FD: It was due to President Rowland and Dean Robert England. When they took over, the Hospital staff was probably not involved in much. That was a whole thrust. They wanted whole-time people who taught and practiced at the same time. I think that was a big improvement. That really helped this place to get going again. When I came here, it was almost an empty shell of a hospital and a small college.

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

FD: I'll look at PCOM from a distance. When I was working in Chicago, we would get students from PCOM as interns or residents, and I was always interested in them because of my interest in my alma matter. The reputation that the students had when they graduated from PCOM -- "great academically and poor

clinically." The classroom training has become excellent. The students had always placed high on national boards. I guess one thing that stands out is -- while I was here one year, our students placed the highest in obstetrics on the obstetrical boards. I think that's continued. But it's only been recently that students have been more involved with patients in taking care of patients, rather than didactics. When they are a graduate from here they have a fantastic training and education. They have fantastic ability. When we graduated from here, we had it up here, but we didn't have it as far as patient care was concerned.

CBP: But now you feel it's well integrated?

FD: Oh, yes. Oh, yes. Much more. I retired in 1991. I don't know what's happened since then, as far as teaching and training is concerned. But up to that time, it was excellent. Our students were accepted in M.D. institutions for residency training programs and for intern training programs. As I said, we

weren't defeated. We were amalgamated. [laughs] We were integrated. [laughs]

CBP: [laughs] One last question. What do you see as the primary challenges and goals for PCOM to meet as it approaches its centennial and the 21st century?

FD: It's got to remain an osteopathic institution. If we forget the osteopathic concept and fail to teach it, then we are not a different school of medicine. And I think it's important that we remain a different school of medicine.

CBP: That concludes my prepared questions for this interview. Is there anything else you would like to add or talk about? Things I might not have asked you about, that might be important for the history?

FD: Well, I think it's important to remember the men who worked here without any pay, to keep this institution going during the dark days. When I was awarded the O.J. Snyder Award, I said in my acceptance speech that I was so thankful for the men who worked here many times without renumeration and

kept PCOM going so that I and others could get the education that we got, and so that it could be where it is now. The pictures you see on the walls, and the men who worked their own practices and taught here and those who have not been so recognized. The Baldwins, Clarence and Bill, William Spaeth, Samuel Caruso, Bill Morris, Nick Nicholas, David Heilig, Paul Lloyd, Robert Meals, etc. I have no idea who got paid and who didn't get paid, but I know since I've been back, I'm hearing other physicians, saying how they had taught and conducted clinics without any pay. But that's the thing. Don't forget the history of this place. Don't go by the reputation at times, because the reputation at times was poor. But other times it was great, and all of us who graduated from here are very thankful for those who kept it alive for us. And I'm especially thankful because my son-in-law graduated from here, and he's doing very well, and he's an osteopathic physician.

CBP: Thank you very much.

FD: Thank you.

End of Interview

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