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## Joseph Dieterle Oral History

Philadelphia College of Osteopathic Medicine

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INTERVIEW WITH JOSEPH A. DIETERLE, D.O. (CLASS OF 1970)  
by Carol Benenson Perloff for the  
Philadelphia College of Osteopathic Medicine (PCOM)  
April 23, 1997

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

DIETERLE:

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

JD:

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

JD: Well, I was a young fellow, growing up in Philadelphia. Our family physician was an M.D. -- a homeopathic physician -- a graduate of Hahnemann. He was actually the only physician I knew for the majority of my life, and he was the epitome of the true family physician of his day, making house calls. He delivered me at home, as a somewhat premature child. Now, I guess it was a difficult pregnancy, since my parents were married ten years before I was delivered. Anyhow, he made house calls and practiced alone, had no nurse, had no receptionist. He was my role model. The day I was



supposed to meet him for my physical for college, and to sit down and receive some advice and guidance -- he was going to mentor me through school -- he died the day before, necessitating, over time, our family assuming another physician in the neighborhood. And the only family physicians that really you could find in those days -- in the area -- the people that were taking over primary care were osteopathic physicians. The old family doctor died when I was maybe sixteen. I was an athlete in high school and college, participating in baseball, running and swimming, and had several injuries. And when I assumed a relationship with the D.O.s in our area, I realized just how much they had to offer, in regards to physical medicine, as well as the general scope of medicine. I became more interested, I got to meet more people in the area. Other members of my family had gone to D.O.s all of their lives. So I spent some more time talking with these individuals, and felt that there was a real opportunity with the musculoskeletal emphasis of



osteopathic medicine to further my education, and I felt that the D.O.s offered a broader scope in regards to the general care of the population because of their knowledge of the musculoskeletal system. So because of that, my personal experience in being injured and hurt here and there, and their abilities to get me back on track. I really spent a lot of time looking into osteopathic medicine.

CBP: Who was the D.O. who became your family practitioner?

JD: Actually there were a couple. There was Stuart Baer, who practiced on Cottman Avenue at the time, and John Crawford, who, I think, is still alive, but practiced in the Northeast, also. Some of the other D.O.s who took care of other branches of our family whom I got to meet were Francis Belz, who practiced in Olney, and Al Fornace, who practiced in Olney, and then eventually practiced in Norristown, at Suburban General, one of the founders of that institution. Actually, Albert D'Alonzo was a resident who called on these people way, way back



when, to take care of them.

CBP: Do you know if these were PCOM grads?

JD: All of them. All of them. Dr. Fornace -- he's in the corporation at PCOM. Francis Belz is dead. I think Baer still practices in the northeast on Cottman Avenue, and I think John Crawford is retired.

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

JD: I graduated with a Bachelor of Arts in biology from LaSalle.

CBP: Why did you select PCOM for your education?

JD: It was home. [laughs] It was Philadelphia. And because of all the influence of these individuals who gave me the opportunity to spend some time looking at the institution, learning about the institution. Like in all the schools, competition was tough. If I knew these people, it was helpful. Dr. Fornace took me on rounds, took me to some conferences at the old North Center, which is long since closed, up in North Philadelphia -- the old



North Center Hospital. He used to do a kidney program up there and case presentation. And then he took me on rounds at Riverview. So it was what we knew. It was what I knew. It was Philadelphia. So that's really where I wanted to go.

CBP: Did you even apply elsewhere?

JD: Sure. I applied to Des Moines. I guess Kansas City, Temple. I don't know where else.

CBP: So you applied to allopathic, as well as osteopathic?

JD: Sure. Yes.

CBP: What were the highlights of your educational experience at PCOM in the late 1960s -- courses, professors, etc.?

JD: Well, first of all, the highlight was being accepted. You know, it was really a plus. I got accepted with some good friends that I knew, and actually, it gave me a chance to reunite with some high school classmates of mine. Several of us had done some graduate work or a year post-graduate, which I did, also. I went to LaSalle again for



another year and did some other work when I had no other constraints on my time, like swimming and running, and things like that. And I guess some of the other fellows did some Master's programs, also, so I went back to school. When I got to PCOM, I ended up with two high school classmates and several college classmates who had done the same thing. It was real exciting to be there and it was a great course, particularly in our freshman year. The real down side was that I guess my class in particular really got rocked and socked by some professors. I think we started with ninety-seven people and graduated eighty or eighty-one.

CBP: Could you explain that a little bit more -- rocked and socked by professors? And why your class in particular?

JD: Probably the premiere anatomist of his time was a man by the name of Angus Cathie, who really taught us a course in anatomy that was by far, I'm sure -- I can't compare it to anybody else's, but I'm sure it was by far, the most outstanding anatomy course



that anybody could ever have. And because of that, I think, all of us know a great deal about the human body today. Angus Cathie was certainly a plus to our educational experience in that regard. However, there appeared to be sometimes -- I think in our class -- a subjective approach to rating systems. We also had a chemistry teacher, Albert Kline, who was, I think, legally blind. He gave some tests -- some people had old tests for, and some other people didn't. So it was an opportunity -- as an example, half the class would flunk the tests sometimes, so it was used as a way to, I believe, admonish the class for whatever reasons. It was not unusual that half the class would be flunked in something. It wasn't unusual that we would have two-thirds of the class flunked in something.

CBP: All in chemistry?

JD: Lots of chemistry, anatomy -- whatever else. So that at the end of my freshman year, eleven people were thrown out of school. And I think that even having been in administration later on in my life at



the College, I think it was a subjective approach. I think it was unfair in many of the instances of the eleven. Two or three were allowed to repeat, which I think, after having gone through the first year of medical school at PCOM -- PCO in those years -- it was a difficult year. It was a satisfying year, when you accomplished it. But it was also a year spent, worrying about how you were going to be taken down, and perhaps not justifiably so.

CBP: Did you feel that your class was singled out for this, or was this going on a few years before you or a few years after you?

JD: I'm not sure. It's hard to speak about the other classes. Nobody lost that number of students that I know of, in the history of the school. I mean, there were retakes and you just didn't know -- you just didn't know how it was going to be graded, where it was coming from. You know, it wasn't that people didn't study and it wasn't that people weren't taking it seriously. I just had the opportunity last week to spend time with one of the



fellows in my class who was made to repeat, and it was devastating to him. To this day it was devastating to him. His father was an alumnus of the College. It wasn't like he was looking for special handling or anything like that. It's just there was an extremely subjective approach to the grading process. People in the class felt, unequivocally, that you could be gotten if you looked the wrong way, acted the wrong way. I wasn't sure that was true because I was generally successful. But, boy, I'll tell you, it really took away from the fun. It took away from the reward of learning what was available to us. It took away from the successes of going through this year, which was a tough year. It deflated everybody's sails. I remember finding out about the eleven classmates on my wedding day, and it was a disaster.

CBP: At the time, did you feel there was any administrative recourse for you -- as students? People you could go to?

JD: Sure. I went to Tom Rowland, everybody's buddy.



[laughs] I went to Tom Rowland, who was at that time, Director of Admissions. I told him. I said I thought he was somebody I could speak to without admonishment, without having it come back to get me. I flunked chemistry. I never flunked anything in my life through school there. I did well, I thought, in everything. He said that one of our old professors saved me, and he shared this with me, and he told me that Dr. Ruth Waddel Cathie spoke up at a meeting and because at that meeting, it was said that I was living with a woman. I was living with a classmate. His name was John Becher, who was professor of emergency medicine in our freshman year. That I was living with a woman, and that this was inappropriate, and I should be thrown out of school. It was complete innuendo. I have no idea what they were talking about. Tom Rowland told me that Dr. Ruth Waddel, at that time -- she hadn't been married to Dr. Cathie yet -- spoke up and said this was inconsequential. It had nothing to do with my academic standing. He shared that with me years



later, actually. But when I did go in and talk to him I said, "You know, this can't happen. This is inappropriate." I was angry, actually, and I said, "It took me long enough to get in here and nobody is going to get out of here without a fight." He said, "Well, you're right." And I know that over years, he couldn't straighten that out, and later on in my academic career in the College, I turned myself inside out with the help of a great faculty, to make this institution a fair institution that removed all subjectivity to the grading system and your abilities to stay in that school.

CBP: When you were in school it was a time of tremendous social turmoil on college campuses -- late 1960s, getting into the early 1970s. Do you think perhaps their coming down hard on all of you was a reaction to what was going on in the country at that time, or do you think this was just what was happening at PCOM? It does sound very archaic that they had concerns living with a woman at the time when the sexual revolution was going on throughout the



country.

JD: Well, it was not only that. I had nothing against this because I think roll should have been taken. When everybody came to class, we looked like gentlemen, we wore coats and ties, we acted like gentlemen, and I can remember when -- because of long hair -- the people were pulled out of the classroom, taken down to the auditorium and said, "Cut your hair or you'll be dismissed from school." 1967, I guess, it might have been. It was the era of Kent State. I could sense -- even I felt there was some guys in the class who were a little less mature than others -- men who would kind of talk out to the professors, and I think it aggravated some. It was a little lack of respect on their part, and I think that that probably brought down some rap on the class as a whole. But the class as a whole, compared to today -- the way the people dress and act in a classroom, come and go as they please -- it was a role model. But they paid. They paid dearly, some of them. Many of the fellows went on to other



schools. I believe three returned to the class behind us and several returned to other osteopathic schools. I can't say this for sure, but it probably was with the help of Tom Rowland.

CBP: Do you happen to know from a development standpoint how your class has been involved as alumni?

JD: I don't know. When I look at the development numbers, I would have to say that the quantity is not there, but the quality is. But I know there's still a lot of hard feelings because I used to make the personal phone calls from the phone-a-thon to my classmates, and I'd wrestle some dollars out of them. And I thought that my presence back on campus with several other of my classmates, like John Becher, would help smooth this over. The threat was always there that if we were caught on another medical school's campus, or with an allopathic physician, or in their hospitals, that we would be dismissed from school. That was a feeling everybody had. I don't know if it was true or not, but that was what everybody felt. And that's a shame.



Instead of taking the best and the brightest of what we have in osteopathic medicine and showing our worth to other institutions, it was looked upon by some of the older people as the wrong thing to do.

CBP: When did the notion of cross-training in the allopathic world become acceptable?

JD: Oh, I think the class before me had a couple do that, and my class. The Class of 1969 and 1970, I think, were the first people.

CBP: As far as going into allopathic residencies?

JD: Yes. Oh, for years, everybody moonlighted. Everybody went out -- I can tell you for sure -- people in my class, myself included -- we would leave our lectures after school. Remember, we went to school for three years and had anywhere up to thirty examinations sometime. Every trimester. It was really a treat.

CBP: It took three years before you had clinical experience?

JD: Yes.

CBP: That's what you were referring to when you said



three years?

JD: Yes. Three didactic years and one year of clinical. With that last year -- that third year -- having up to thirty exams for a trimester. Crazy.

CBP: When did that third year shift to being clinical, as well as didactic?

JD: I think somewhere around 1972. It was after I graduated. Somewhere in that area -- early 1970s. But I can tell you that people used to leave my classroom and it wouldn't be unusual. They would go and spend the whole night -- from seven at night -- with a night intern at an osteopathic hospital. Spend the whole night -- till maybe three or four in the morning, when things quieted down -- with this intern --

CBP: Did you say an osteopathic --?

JD: Oh, yes. An osteopathic hospital. And go and spend the night with an intern, and then go home and go to bed for two hours, get up and shower, and go back to class. Just so you got more clinical experience. We would hang around with them in the emergency room



and go see patients on the floor with them. If there were deliveries and the attending would let us come in, we would go in and watch, and they'd teach us. People had jobs in other hospitals as "pseudo-interns," helping out, doing histories and physicals, and that's how we got extra clinical training. But the threat was always there -- real or imagined -- that if you got caught, you were dead. People would spend time in allopathic institutions. I would go to Ground Rounds at St. Christopher's which is obviously interested in pediatrics. I was invited to go, so I went.

CBP: Did the administration know you were doing that?

JD: No. No need to tell them. I don't know if it would have made any difference, except that I was criticized by people when I did do my internship my residency at St. Christopher's Hospital for Children.

CBP: I wanted to ask you a few more questions about your experiences as a medical student, and then we'll move on from there. You were among the last PCOM



graduates to receive your classroom training at 48th Street, and the first to receive clinical instruction at the new City Avenue Hospital. Please share your recollection of both facilities at this time of transition.

JD: Well, it was night and day. [laughs] My senior year we were still at, and out at City Line Avenue. 48th Street was really an interesting old place. It was sort of a flashback, I guess, and still is, when you look at old pictures of hospitals. It was old, no question about it. It was an old institution. But fun. People were great. Small, but the experience was there. I remember giving tours through the new hospital on City Line Avenue before it opened. As a member of Student Council, we were asked to do these things. And having such a sense of pride -- you'd go out to City Line. Here was our beautiful new campus. There was a sign on City Line Avenue that seemed like it sat there for a hundred years which said, "Future site of Philadelphia College of Osteopathy." Finally it was reality, and



it was a real uplifting experience, I should say, to go out there and have this new, shiny facility. It had nothing to do with the quality of the didactics, but it was just an opportunity to showcase ourselves. It was nice to have people be able to come out and see the Hospital. It was easy to get to for patients, I guess. But there was something that was revered, I think, about the old institution. Actually, when I went back to the College as a teacher and professor, they still had clinics over at 48th Street, before they sold it, and I had the opportunity to wander through, and it really brought back some great memories. Up to the old classroom, up to the old anatomy lab, and over into the Hospital. I said, "You know, it was a lot of fun." I mean, you spend a lot of years there, you know, and you go through a lot of blood, sweat and tears. Like pop anatomy tests and losing good friends, and things like that. To go back five years after graduation and have the opportunity to wander through the place was something a lot of my



classmates didn't have an opportunity to do.

CBP: If you had the opportunity right now, would you like to go back and walk through that building?

JD: 48th Street? Oh, absolutely. Absolutely. I know it's been sold, and I did go through it just before it was sold. It was a lot of fun. You know, they had the clinics in the basement, and they had, of course, the classrooms, and Tom Rowland's office and the Dean's office, and all these neat little places. The library. You still remember these people's names, and I flip through our yearbook periodically and look at the old people who taught us. And not just the professors, but the behind-the-scenes people. I remember some of their names. I can still remember my first day in anatomy class.

CBP: Did you feel that you were splitting your time between the two campuses, or did you really just miss that point, where you were going back and forth between the two?

JD: No, I didn't feel that way. No, I didn't feel it was a detriment. I think that all of my didactic



experience was at 48th Street. So that in my senior year, we were, I believe, the first class to have an off-campus PCOM clinical experience. That was the only rotation that I know of that any PCOM student ever had that was sanctioned, and that was at Suburban General Hospital. And I had the opportunity to do that. I think just around my senior year -- maybe the year before, but I know at least in my senior year is when there were a great deal of changes starting to take place. Classes were getting bigger. The new hospital opened. We had our first off-campus experience in another institution, where we weren't going to be tainted by anybody. And that was at Suburban. So I think that that was the era of change and growth.

CBP: Did you get clinical training at the City Avenue Hospital, or did you still do that all at 48th Street?

JD: No, I had both.

CBP: Both?

JD: Yes. I had both. We had two clinics to go to, as



opposed to today, when they have a half a dozen of them, or so, or eight or something. We had 48th Street and North Center, which was North Philadelphia. I went to North Philadelphia.

CBP: Could you describe the experience in North Philadelphia -- at 20th Street, North Center Hospital.

JD: 20th Street. That was it. Well, the entire institution was closed except for the clinic. I think it was a great experience. It was our first clinical exposure to patients.

CBP: Is this your fourth year?

JD: It's in our fourth year. Remember, we had three years of didactics. So here we are, turned out in public. [laughs] With some supervision. Obviously, there was a physician there. We all had our own little practice in our booth, as we would kiddingly call ourselves the "booth doctors." You were in booth 1, 3, 7 -- and that was your identity. My booth doctor was Booth Dr. so-and-so, and you had your bank of patients, and the drug salesman would



drop off samples, and we cared for the population of North Philly and the area. Some of the specialists would come over once a week. OB/GYN, orthopedics, surgery, and frequently it would be residents or attendings. We'd have a lecture here and there. Actually, I was so enthusiastic about the place, I went to Tom Rowland and said, "Why don't you start an emergency room over there?" It just goes to show how much I didn't know, or what it takes to start an emergency room, and how much money it is, and what kind of back-up you need.

CBP: That would have been shut down.

JD: Oh, the Hospital was shut.

CBP: The emergency room was one of the first things that was closed down when PCO acquired North Center.

JD: Right. I thought it would be a great place to have an emergency room, right there in the middle of North Philadelphia. But again, not knowing the expense and the overhead of an ER, Tom just laughed -- pushed me on my way. But it was a good experience. I think more oversight was probably



needed at the time by attendings for these young bucks who were wet behind the ears and had no clinical experience. It would have been helpful, I think, to have someone overseeing. So we all walked around with our notes and our books and our handbooks, and had a good time, actually. We learned a lot.

CBP: Did you get more supervision in the 48th Street Clinic than you did at 20th Street?

JD: No, I don't think so. I think they were the same. Except I think at 48th Street, you had the doctors, also, upstairs in the Hospital, so that it was a little bit more hustle/bustle, I think, over in that area. In our clinic, there was nobody around but us in the Hospital -- the whole building was shut down. But it was really an interesting place to go to. [laughs] It's a shame they shut it down.

CBP: Did you ever rotate through PGH?

JD: No. No, they didn't have any rotations at PGH. No outside rotations.

CBP: Was the Harbor Light Clinic still open when you were



a student?

JD: Yes, I went there.

CBP: Could you tell me about that?

JD: The Salvation Army. That was a real sight. Down on the old Vine Street before the Vine Street Extension, and the bridge and the things like that - - the underpass, and so on. We went down to Harbor Light and cared for the folks down there, and that was a real, real indigent crowd. I saw all kinds of disease. That was incredible. I remember students coming out -- you know, we all wanted to go home and take a shower, and clean and sterilize all of our equipment in our little black bags that we got. But it was pathology that we would never see again.

CBP: I understand it was on a volunteer basis?

JD: Yes, I believe that's how it was. I forget. I think it was on a volunteer basis. But you know, it was an opportunity for the students, after having spent three years in a classroom. And remember, we spent three years in a classroom, wearing a coat and a tie, and we weren't allowed to wear white coats



until you were a senior. So it was an opportunity to take the little black bag that somebody gave you -- a drug company -- and the stethoscope that the drug company gave you, or the new one that your mom and dad bought you, or your grandparents, or your wife and you got together and bought your diagnostic kit. These were all great triumphs of your academic medical career. So you put all that stuff together, and here you went off as this doctor. So you used every possible experience you could to exercise your newfound knowledge. But we were only scraping the surface. But still, it was fun. So that's why people went out and spent time at hospitals. That's why we went out from seven at night until three or four in the morning, to learn more. I think the students looked at it as an opportunity to make themselves better, and I think their fear was that the school would look at it as a way of pointing fingers at the school and saying, "You're not teaching us enough." It's like more is better. I think that's how our class looked at it, anyway.



And then people went out. They spent time at mostly osteopathic hospitals. Metropolitan, Kennedy Hospital, and the old Parkview, and Delaware County, Tri-County. People would go out there and spend time with the interns here.

CBP: When did students stop wearing coats and ties to classes?

JD: I don't know. I wasn't there. It happened after the time I graduated. I was only gone four years. I graduated in 1970, and returned August 5, 1974.

CBP: And by then the coats and ties were off?

JD: Coats and ties were gone.

CBP: So sometime in the early 1970s.

JD: As I recall -- the coats and ties were off. Some of the classes were still being held at 48th Street. But as I recall, the coats and ties were gone. So somewhere in there it happened. And the two-and-two concept -- two years didactic and two years clinical -- came about.

CBP: Please share your recollections of Dean Sherwood Mercer, and comment on his contributions to the



College during the late 1960s.

JD: Well, I think there was no question that Dean Mercer was our Dean -- he was my Dean for three of the four years I was at PCOM. I think as a student -- at least as this student -- we didn't have a lot of touch with the Dean at the time. I'm sure he had a lot to do with furthering the growth that we took academically as a school, to engineering that change to three years in a classroom to two years in a classroom. Dr. Mercer was a good friend -- still is a good friend. I haven't talked to him in a while, but I think he had a great deal of furthering the College. But I think that when Paul Thomas became Dean, he actually presided at our graduation. I think the students could identify with him more. Dr. Mercer taught us the history of medicine, but he wasn't a physician -- he wasn't a D.O. We didn't see much of him in the classroom. He didn't come up and talk to us as a Dean or as a physician. And when Paul Thomas took over, he was a Ph.D and D.O., and everybody had a great deal of respect and



admiration for him because we know that when he was teaching us, before he became Dean, he was a Ph.D candidate. He was somebody you could talk to, and you felt there was going to be no retaliation for anything you said. Everybody was walking on eggs. And I don't know if this was something that was handed down to us, so that when you walked in the school, you started out hitting the ground, being paranoid, or whether it was something that grew on you. It was probably a little bit of both. But Paul Thomas was a person you could sit down and talk to, and I'll never forget when I heard he had died. It was just such a shock because we really thought this was a man that was going to lead this institution for a long time to come. He was young when he died. We knew he was sick because he took on so much stress. He lost weight -- he looked terrible. I was away at my internship to visit him, just to stop into the College and told him I'd been accepted to St. Christopher's Hospital for Children. And the next thing you know, he died. It was really



a shocker because he was the guy I think everybody was really counting on -- I think, as the students would say, "straighten it out." [laughs] I'm sure the faculty didn't think it needed straightening out, but the students thought it did.

CBP: What were the highlights of your social experience at PCOM and in Philadelphia in the late 1960s?

JD: Social experience? Oh, let's see here. Well, I met eighty-one new friends. It was really a close-knit group. You helped each other, you worked together, and to this day, I could pick up the phone and call probably anybody in my class and talk to them like it was just yesterday, which was what made the phone-a-thon fun for me. But that was a great social experience. Just learning and meeting these folks, and they were people from around the country. I personally lived a rather sheltered life in Philadelphia. I was born in Philadelphia, I was raised in Philadelphia, I went to grade school in Philadelphia, I went to high school in Philadelphia, I went to college in Philadelphia, I went to PCOM.



I didn't know anybody from anywhere except now, all of a sudden, I met people of all different walks of life. They were older. And I had a very traditional, educational Philadelphia experience. I met people from different colleges, different states, different backgrounds, single guys, married guys, people with two and three kids, making a great deal of sacrifice to go through school. I really enjoyed it. The fraternities in those days were strong social arenas.

CBP: What fraternity did you belong to?

JD: Phi Sig. They had Phi Sig and ITS, Atlas and Log. That was it.

CBP: What was the role of the fraternity at that time?

JD: It was a social experience. It was a place to live for people.

CBP: Did you live there?

JD: No.

CBP: Did you live at home?

JD: No. Dr. Becher and I lived together. We were college classmates, so we got an apartment together



for a year. I got married at the end. I was engaged in that year, and then he moved into the frat house after our first year together. But we didn't know anybody else. We went out, found an apartment the summer before first year. We got our first year -- we got the apartment -- which was the old Croyden Apartments -- 49th and Spruce -- which is where I was supposedly living with this lady, whoever it was. [laughs] But they were social. Each fraternity had different parties. They'd make sure that nobody conflicted with gatherings most of the time. We'd try to support each other's parties because if ITS had a party, they would advertise it, of course, to the undergraduate college, the nursing schools, so everybody would come and support their thing, and they would support ours. Actually, there was a lot of camaraderie. And it was helpful to have upperclassmen to help you with the ins and outs of what you think you should know and the different profs, and I think it might have been -- that was part of the mystique, you know? Going to a frat



house. "Oh, yeah, this junior told me watch out for this professor, watch out for that one." There were all kinds of innuendo. They had the best bank of old tests, and that was a problem, in some instances, I think. It helped with the demise of some people in my class, I think.

CBP: When and why did fraternities leave PCOM?

JD: I think they waned just like they did on the undergraduate campuses. I think that that old collegiality that was present on most college campuses has floundered in graduate schools, too, I think. People formed their own little cliques in the joining of a mass group. I don't think for years and years frats appealed to people. Phi Sig is the only active fraternity, I think. Maybe I'm wrong. I don't know if Log still has a house or not. They had one, but I heard they sold it. I'm not sure what happened to Log. I know that Phi Sig still has its house over in Germantown.

CBP: Yes.

JD: Actually, I helped find that house -- Dr. Becher and



I.

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

JD: Tom Rowland's teams were before my time. No, there were no organized teams that I knew of. I know we played some intramurals. We played some basketball. That was about the extent of it. Actually, I think my class or our team -- whatever -- somewhere in the attic might be a trophy for basketball. But we would get together, go play touch football at Belmont Plateau on some afternoon, and periodically, members of the class would get together and do something here and there. But there were no sports like competitive sports with other schools. There was really not much time for that, you know? Really I think things had changed a great deal. It was an awful lot of time spent with academics. We had unannounced anatomy tests for a full year. You just couldn't afford to be behind in that stuff, in particular. You could walk in on a Saturday



morning. We had classes on Saturday mornings. And it was anatomy. So you had anatomy from eight to nine, the laboratory from nine to twelve. You could walk in Saturday at eight o'clock and they had it right on the board, "Report to the auditorium." That was it. You had a major test. If you weren't prepared, you were dead. So forget about going out on Friday night unless you were way ahead. But it was just an inordinate amount of work. I think that one thing that everybody looked forward to was what they called it in those days -- the Christmas Show. I don't know what they call it now. Flounder's. That's what it's called. But it was called the Christmas Show. It was a spoof. It was a spoof where the students all got together and took a whack at the profs and the administrators, and did skits and things like that. And, on occasion, the profs did it to us, so we had a good time.

CBP: Do you know when the skit was started?

JD: No. Years, I think, before I got there. And it goes on today, I think. Actually, I even did it as



a Dean. [laughs] But it was always a lot of fun. It sort of lightened the load a little bit. It took the edge off. Everybody was -- at least in my era -- everybody was on edge. We were afraid. You know, you shouldn't be afraid. That was the wrong atmosphere to be learning medicine. We were afraid of a nebulosity. There was a fear, but of what we weren't sure. Of being thrown out for something that was unreasonable was probably the bottom line. But everybody admired people like Dr. Finkelstein and Albert D'Alonzo. These were people you could deal with. Nick Pedaro was a great guy. He went hunting with us. People you could talk to. Albert D'Alonzo you could sit down and talk with. He talked medicine, and then he'd get off on a tangent, like Albert was one to do, about baseball because he was a great baseball player. You know, I don't think we got to really appreciate some of the expertise of the individuals who taught us until later on, at least I didn't. But you could deal with them as individuals on a friendly, fine basis.



But during that first year, having to deal with the people we had to deal with -- boy, I'll tell you -- it was one of the most stressful situations. Not on the academic load, but with that fear. That fear of being dismissed without cause. That really took away from a lot.

CBP: Please describe the specific training you received in pediatrics -- both didactic and clinical -- while you were a medical student, and please comment on the pediatrics faculty at that time.

JD: I'm trying to think what we had in pediatrics. There wasn't a great big load of pediatrics in those days. We had some good professors. At the time I think the Chairman was Dr. Spaeth, and we had Dr. Purse and Dr. Caruso and Dr. Santucci, who was outstanding. Dr. Berman. We had a resident for a while, Dr. Godfrey. Actually, my first son was born in PCOM Hospital when I was a junior. I think our best experience was Dr. Santucci teaching diseases of childhood or something along those lines, and it was really a good experience with what he taught us.



Clinical experience -- we had a few children on the wards. And, of course, children in the clinics who came to our practices. That's about it.

CBP: Was anybody in particular a mentor for you in pediatrics?

JD: No. It was the subject of pediatrics that really attracted me. The kids. The kids are honest, they're straightforward, you can talk to you. They'll talk back to you if they trust you. They don't distort the truth. And they see through a facade. Plus, dealing with kids tests all of your diagnostic skills because they don't communicate like adults do. So you have to utilize all of your skills as a clinician to tease the truth out of them. I mean, I use that not because they're lying to us -- because they don't. Because you need to figure out what they're telling us without words. Actually, I did a lot of coaching with kids through school -- college and medical school -- and really developed a liking for the children. I think I honed that experience as an intern at Flint,



Michigan when I was out there. They had a large pediatric facility which really helped me. Because when I was at PCOM, I wasn't sure if I wanted to be a pediatrician. Actually, I thought I wanted to be everything. [laughs] I thought I wanted to be a family physician, and then every time I left the service, which is classic today -- your last professor is the guy you want to emulate. So I wanted to be a cardiologist and a general internist and a surgeon. And then it really was a toss-up between OB and peds.

CBP: Did you do a rotating internship at Michigan?

JD: Yes. Flint Osteopathic Hospital.

CBP: And then you served a pediatric residency at St. Christopher's from 1971 to 1974, is that correct?

JD: Yes.

CBP: Were you breaking ground in being an osteopathic resident in that institution?

JD: Yes. There had never, ever been an osteopathic resident in that institution. And I paid dearly for that, at least in our profession.



CBP: Could you explain that?

JD: Sure. I've been criticized for my allopathic training by people within PCOM. But let's face it. I still got to be where I was at the College, despite that. But I was criticized for that by people at the College for years. When I first went back there, there were people who told me to my face, and through the back door, how I would never be certified by an osteopathic board, and how I would never amount to anything in the osteopathic profession, and so on and so forth. Also, though, on the other side of the coin, there were many people who came to me and said, "It's nice to have you. Thanks for what you did." Because I looked at it as taking what I was given through PCOM and through my osteopathic internships -- through all the mentors I had, good and bad at PCOM. I took that experience and I was able to show other people just how good we were, and my training was. I was accepted as the first resident at St. Christopher's. I excelled there, and I was their chief resident in



my last year, over people from Jefferson and Yale and Southern Cal and lots of other places. I felt good about that, personally, as well as professionally. But other people in our profession don't look at it that way. I was board certified by the M.D.s -- by the American Board of Pediatrics in about 1976. I wasn't board certified by the American Board Osteopathic Board of Pediatrics until 1980.

CBP: What were the implications of that as far as your being able to practice?

JD: Oh nothing. I could practice anywhere I wanted. I mean, I had my rotating internship. I think it pointed out just how Tom Rowland would take a chance. Because when I was still a resident at St. Christopher's, I would stop out at the College periodically because it was near and dear to my heart. And I was criticized when I was out there for being non-osteopathic. What people didn't understand was that my father was operated on out there, my uncles were operated on out there, I had



an aunt operated on out there, my son was born out there, my daughter was born at Flint Osteopathic Hospital, my wife was operated on out there. I sent a multitude of people out there. But there are a lot of vindictive people in this world. But anyway, Tom Rowland took that chance, and I owe him a great deal of gratitude. He called me and said, "We'd like to have you come back to the College." I said, "You're not going to take a lot of heat for that?" He said, "Who cares?" And I appreciate all the work that Sam Caruso did to help me get certified. And the Dean -- Dean England at the time. And a lot of other people who helped pave the way for me to get certified in our profession, and to overcome what other osteopathic physicians thought was a turncoat approach to our profession.

CBP: What did you need the certification for?

JD: Well, if I wanted to be a trainer in our profession. If I wanted to continue in our professional training. It didn't have anything to do with my practice of pediatrics. But if I wanted to continue



training in the osteopathic profession. If I wanted to continue developing our department of pediatrics at PCOM, I needed to have that. It would be best that I have that. I could have used Dr. Caruso's credentials, as we used his. We could have used other people's credentials. But it made me complete, so I wrote the boards. I've written both boards. There are very few people who have done that.

CBP: Why did you go out of the osteopathic world for your residency?

JD: St. Christopher's Hospital for Children is considered one of the best children's hospitals in the world. There was not an institution in our profession that had that kind of training at the time. There were very few institutions that were even sending their residents out of the institution for training. So, as far as I was concerned, there was never a doubt where I was going to go for training. We didn't have the depth. And because of that training, I was able to bring it back to PCOM.



I had a number of people who said to me, "Why would you ever go back to PCOM? Why would you ever do that after what you have?" I mean, I could have stayed at St. Christopher's. I had many offers to go many, many places. That chief residency at that institution was a key to many institutions. First of all, I cared a lot for Tom Rowland, I was really very grateful to the institution. So despite the narrow-minded individuals who took shots at me for my training, I knew there were a lot of students that I could have a great deal of fun with, and there were a lot of profs that didn't care where I did my pediatric training, and that I could go back there, and I could just enhance what people like Dr. Santucci and Spaeth and Caruso and Purse and Berman and everybody else had started. That's all. It was just a growth process as far as I was concerned. So when I had the opportunity to come back and do that -- and actually, when Tom called me and asked me and I said, "Yeah, I guess," I really, truly didn't think I would be there for more than a year or two.



I thought it would be just a trial and error type of thing, and again, people were saying, "What are you going to do about this?" And patients. "What are you going to do? What are you going to make this three years of high powered training do back there?" I said, "I don't know. If I don't like it, I'll leave." I loved it, so I stayed. [laughs] Fifteen years I stayed. We developed one of the best pediatric programs in our profession. We had eight residents at one time. We had the first tertiary care facility at PCOM, and it was the only one where people were sent in from other hospitals for the NICU. We got that all set-up.

CBP: For pediatrics, or in general?

JD: No, the whole institution. That was the only tertiary care facility, where patients were brought in from outside. It was a recognized tertiary care facility in that unit. It was actually like a level -- 2.5 -- they grade these things. But still, it was something. I really enjoyed the students. You know, when you're a pediatrician in a general



hospital, you have to fight, you know? I'm sure I stepped on lots of toes on my days there before I was Dean and everything else. I fought people tooth and nail for the care of kids. You know, they all have to make some decision and not ask me. I said, "You can't make those kinds of decisions. Talk to a pediatrician." And they would think, "Who is this guy?" I would say, "I'm an advocate for the kids. You've got to ask me first before you can do something with the kids." And I'm still critical today of the institution. They don't teach enough pediatrics. They've gone backwards.

CBP: Even with the increasing emphasis now on primary care?

JD: Yes. Find out how many hours they have. They cut them. When I was there, we had eighty hours in pediatrics. I think there's still too much surgery and things like that. Diagnostics -- yes. You need to know how to make the diagnosis and all. But they were showing surgeries of how to do this and how to do that. What for? What for? At one time they had



thirty hours of pediatrics. Thirty hours of pediatrics. A hundred and forty in medicine. Fine. That's an important course. A hundred and forty or fifty in surgery. You know, pediatrics was off to here. I said, "How can you do that in a primary care institution?" You talk osteopathic medicine. I get criticized and people like me get criticized all my career for not being osteopathic. That's a crock of nonsense, all right? I know primary care.

[end of side one, tape one]

CBP: You served on the pediatrics faculty at PCOM during the Chairmanship of Samuel Caruso, D.O. Please comment upon Dr. Caruso as a leader, an educator and a clinician.

JD: Dr. Caruso took the Pediatric Department through its developmental phase through the early 1970s, when there was a great deal of change in the specialty of pediatrics. He was an understanding man, who truly cared for children, and he was able to be flexible



in the development of the Department. We worked well together. He knew the changes that had to take place and was willing to work diligently to effect those changes in order to better the Department of Pediatrics.

CBP: Could you tell me what changes were taking place in the practice of pediatrics in the early 1970s that he had to respond to?

JD: Sure. The programs in our profession were dwindling. Dwindling drastically. PCOM hadn't had a resident in years, and many of the other institutions hadn't had residencies in years. People from 1969, 1970 on were being moved to the allopathic institutions because, first of all, our students were good students. I think, "Let's start with the positive aspect of that." I think a lot of our older D.O.s would look at the negative aspect of that -- they only needed you because they needed you to fill a spot. Well, that's nonsense. Our students were excellent students. They competed for positions in the finest pediatric institutions.



They got those positions, and they came back to the osteopathic hospitals -- in many instances to work with the students. Pediatrics was becoming a subspecialty entity, meaning that there was pediatric cardiology and pediatric anesthesia and pediatric hematology, oncology, neonatology. There was so much. It was like internal medicine. In the old days, the internists did everything. Well, then all of a sudden it was pulmonology this and that, and so on and so forth. Well, pediatrics took the same changes so that just as people in our profession went out to get pediatric subspecialties, the pediatricians went out and got this training and brought it back to the institutions, also. So I think that pediatrics was undergoing a great deal of change at the time, and if we were going to develop a residency, if we were going to teach pediatrics correctly in a classroom to the primary care physicians we hoped we were training, then we needed to understand all of these issues, and I think that Sam Caruso knew which direction we had to go in, and



he took that direction.

CBP: In 1980 you succeeded Dr. Caruso as Chairman of Pediatrics. Please describe any significant changes that you were responsible for implementing in the pediatrics program at PCOM.

JD: Well, let's start with the undergraduate years. I think we started that. This didn't start in 1980. I think with Sam's help and assistance, we started the Student Pediatric Club for people who were interested in pediatrics, and we would have little meetings, and I would bring in friends of mine from our profession as well as top gun people who were only maybe residents or fellows at this time, who went on to become chairpersons of divisions at Einstein and in pediatric endocrinology or neonatology. These people came out gratis because I asked them to. They came out and lectured to our students. We started noon conferences -- pediatric conferences at noontime, where I had people come in and give lectures for the interns and the house staff. We increased the didactic hours for the



students to eighty hours. Brought in people -- D.O.s -- from around the city. Mixed our faculty with other prominent pediatricians inside and out of the institution, so that I really felt they got a good, well-rounded education in the care of children. At least a stepping stone -- you know, pediatrics in most of our institutions -- most of our schools -- had nothing but lip service paid to it, so I wanted to be sure that our students had enough didactic education. Our internships only required one month of pediatrics, and before residencies and family medicine, they would have to go out and practice general medicine. So I felt that if that's the case, we need to get as much across to them as possible for the care of children, so we did that. Then we expanded the residency and we got that up from one resident to two residents to three residents to four residents to eight residents. We started a journal club and a Nelson club, and I think we had an outstanding residency program. I think PCOM has probably trained, during



those years, more residents than a lot of other institutions in our profession.

CBP: Were they all being trained at the City Avenue Hospital?

JD: Yes. They were all being trained there with rotations outside the institution, to make up for our deficits. Remember, we didn't have that many subspecialists. We increased the faculty in pediatrics. We had a pediatric cardiologist, we had a pediatric infectious disease person -- Dr. Berg, who was a pediatric rehabilitation specialist, and we had two neonatologists, and we had an allergist for a while.

CBP: This is all City Avenue?

JD: Yes.

CBP: Where were they rotating out to?

JD: The residents? They rotated to Pennsylvania Hospital, they rotated to Jefferson, they rotated to St. Christopher's Hospital for Children.

CBP: Ever with CHOP?

JD: No.



CBP: Why didn't you have any kind of affiliation with CHOP?

JD: I didn't have any contacts there. I could have. I just didn't have the contacts that I had at St. Christopher's. And my allegiance was with St. Christopher's at that time. That's all. And I knew if I picked up the phone, these people knew me and they said, "Can you take one of my residents for a month?" And this was a planned program that I had. The American College of Osteopathic Pediatricians allowed residents to go out for so much time to fill in their gaps, so I sent them out for three months in the first year and six months in the second year. They were some of the changes that we wanted to take place, and I think that when we started the -- and then over the years, from the time I got there, I had started an office practice. And then when we had residents, I spun off our clinic population and made a clinic out of it, so that the residents had their own clinic, so they had a continuity of clinics. A continuity clinic they call it, which is



now the buzz word in training internists and family physicians and pediatricians. You have to have a continuity clinic. We had continuity clinics in the late 1970s at PCOM. Every resident had their bank of patients that was overseen by an attending. And I just developed my private practice at the College, and students and residents could come with me for that, too. So we had a general clinic, where the students went. Each student had their own clinic -- continuity clinic -- and the attendings had their own patient base.

CBP: How was the continuity clinic different than the booth system, where a patient went to a given booth consistently with the same physician or student, as long as that student was still a student?

JD: But residents didn't have them, and over time it became apparent -- at least to the governing bodies -- that residents ought to have continuity clinics. Primary care residencies -- these ought to have continuity clinics. So we started these in pediatrics and the residents had a chance to follow



these patients. So if they were on call, they got called into the emergency room to see a patient. If the patient needed follow-up, they brought him back to the continuity clinic.

CBP: If the residents were then running the pediatric clinic, in effect, what happened to the medical students getting exposure with pediatric patients?

JD: Well, we also had a general clinic. In the peds department, there were three tiers. The attendings had patients and there was one attending who ran the clinic with students. There were residents who had their own continuity clinic. And the students could come to all of them. The students were either in the hospital or in the office setting, or both, depending on what day of the week it was. So they could be there when I'm seeing private patients. They're always there for the clinic. And they were there when the residents were seeing their patients, too. So, as I said, we did Nelson Club, which was the text book of pediatrics. The residents were given those assignments, and the students had to be



there for that. We had journal clubs. So that there was a lot going. The day was full. And it really worked out well. It was an exciting time.

CBP: I understand at one point, the pediatric inpatient unit at City Avenue was closed, and then it was reopened in 1992.

JD: It was closed after I left.

CBP: Could you fill me in? Why was the pediatric unit closed and how could this hospital not have a pediatric unit?

JD: Well, in my opinion, this goes back to -- when I left the chair of the Department of Pediatrics, it was probably 1984 or 1985 -- somewhere in there, I think -- when I became Dean.

CBP: 1983 you served as Director of Medical Education.

JD: No, but I was still Chairman. I held three positions.

CBP: Okay, that was still 1985.

JD: Yes. Somewhere in 1985 I was still Chairman, and I was DME and I was Dean. It was a little too much to do. This was while they were looking for a



replacement. Yes. Peds was an expensive specialty. We didn't have a lot of volume. It was the day of the DRG -- the Diagnostic Related Groups. It was the day of needed volume in the hospital. Financial people were now taking over the management of institutions, and we were being questioned about why we were paying for residents who spent X amount of time in other institutions. I said, "Well, we're a training institution. We're a primary care osteopathic institution. In order to have a program, we need to do this." My goal, from beginning to end at PCOM, was to start a program in Pediatrics that taught pediatricians who seeded the Delaware Valley, and while we continued to develop the services at PCOM with subspecialists in pediatrics, these guys now out in the community would send patients back to us. I mean, I had a grand scheme of how things were going to go.

CBP: [laughs]

JD: There were a few bumps in the road because some of my subspecialists I brought back didn't quite work



out. But that's par for the course sometimes. Nothing ever goes exactly one hundred percent. But then all this hospital stuff started, you know? The financing of institutions of hospitals. You know, the peds unit wasn't full.

CBP: How many beds was the unit?

JD: Well, you know, we got skipped around so many times it was crazy. I don't know. Ten. Somewhere in there. Which is why we needed to train people, which is why we had so many conferences and lectures in the ER and in the nursery. You had to keep going to keep everything -- so that they could learn enough. And a lot of times the administration and other specialties didn't understand. "Well, how come you have to go out? Why are you sending them there?" I said, "Look at the floor, will you?" Pediatricians, number one, don't admit that many kids in today's world. They never did. Which was the difference between myself and some other pediatricians at the institution. So anyhow, what happened -- I guess, after I left -- I knew even



when I was there, they were starting to cut back, or they wanted to cut back on numbers because the Hospital was losing a ton of money. The last year I was there, the College and its income gave the Hospital three million dollars, and I was dead-set against it -- giving all of it away -- when we were raising tuition and it needed props, and I wanted computer equipment. But the financial arm was running the institution, and it was a rocky time. So, as a consequence, I think they closed peds and put it in some corner. Well, that's all the students have to see is that kind of stuff going on. We had some great guys I brought back from PCOM to teach pediatrics, while I was getting further into other areas. But what happened was that the patients weren't put in the hospital, and the interest wasn't there. There were some questions about sending people out and paying for them, so the residency got slam- dunked, and then the doctors started to leave, and that was it. I had no residents.



CBP: From 1983 to 1985, you served as Director of Medical Education at the City Avenue Hospital.

JD: Yes.

CBP: Please describe your role in this position and any particular challenges you faced.

JD: Well, there were lots of challenges in that position. I took that when I was Chairman of the Department of Pediatrics, and Tom Rowland was sick. He had become ill. A good friend of his and mine, Dr. Poppo, was the Director of Medical Education. And for some reason that still escapes me, and I don't know if we'll ever know -- at least I don't know why -- but he was dismissed. Tom came to me, and I knew this was going to be difficult because Richie Poppo was liked by a lot of people. Tom came to me and said, "I need help." This was May. I remember distinctly him saying, "Can you be DME?" He had asked me to do some things even years before. He had asked me if I would be Assistant Dean for Clinical Education, back in 1980. I said, "I'm not ready for that. I don't want to do that. I've got



too many things I want to do in pediatrics yet." So then he asked me, in this 1983 thing, if I would take Richie Poppo's place. I was not happy about doing it, but Tom asked me to help him out. It would only be for a while. "Just get me through this." Because they had residents coming in and interns, in July. So I said, "Okay." So he introduced me to the students -- the intern class and all -- and we took over that position. And then I guess it was January 11, 1984, Tom Rowland died. I think that's the right date. So here I am in this position, and Tom really ran the whole place by the time because he was the President now. I remember going to the inauguration, and how happy we were that we finally got him in there, and we could move ahead. All these changes were due to him and his foresight. Whole-time faculty. It was just a great era. It was a great growth era. And then the hospital situation started. Anyway, I took over this position. As far as I was concerned, it was an interim position. That's when I tried to get our



interns to branch out. I had them going to -- it was another innovative issue. I mean, it certainly had its problems associated with it. We had one class of interns that were really up in arms.

[laughs] But I wanted them to get other experiences. I sent them out to Frankford Hospital. We had talked to them first. They said, "Yes, we want to do this." Well, then they were unhappy with it. Well, I had already made a commitment. I stick by my word. But it was the first time our interns had rotated out to get experience. And it created some political furors. Again, I took the bars from the D.O.s who wanted to take shots at me and the institution. You know, "They don't like D.O.s at that hospital. How come we're sending our people there?" These are coming from the same old guys who, for decades, have told me the same thing and told my classmates, "You know, we forged the way in a world where nobody liked D.O.s" I said, "Don't give me that nonsense. That's what you told me." And these guys are doing the same thing, you know?



So, anyway, that's when we started the new internships. The college-coordinated internships. I started the one at St. Joseph's. St. Agnes. St. Francis in Pittsburgh. A ton of them. Because we were now running out of internship slots in the profession.

CBP: With those programs -- they did their whole internships at one hospital?

JD: Well, it varied. We had kind of mix and matches. The Frankford issue is where our guys rotated to those places. That might have been the only one like that. And then we had some where we sponsored them, like St. Agnes, St. Joseph's, St. Mary's. Boy, they were political times. I really took a lot of knives from other osteopathic hospitals. The AOA wanted this. The institution said, "Let's do this." So we did it, and we tried to be careful with all the political issues. Nothing ever works right. And we did St. Francis in Pittsburgh, and one out by Penn State. This was the impetus for what we have now. The Germantown and St. Agnes and all those



other institutions. That's when that started.

CBP: Was Frankford or St. Joseph's the first allopathic internship that PCOM branched out into?

JD: Well, they are a little bit different. The Frankford one was just a rotation. That was the first one.

CBP: And that was 1984 or 1985?

JD: Let's say 1984 -- right in there. But at the same time, I started independent internships at St. Joseph's and St. Mary's.

CBP: While you were DME?

JD: DME. And then I became Dean. These things continued because I was still DME for six months when I was Dean, and I was still Chairman of the Department when I was Dean. So until I shed some of these things, it took me a little bit of time to take care. Then Dr. Wisely took over. It stayed pretty much that way, I guess. St. Mary's closed down on their own. The Frankford thing we only did for one year, and I discontinued that. But the St. Joseph's one kept going. St. Francis kept going.



Lewisburg was another one. I guess there was a hospital up there, and we really did help the AOA and our students, because there were too many students coming out in the profession and PCOM for the internship slots. So here's a profession that says, "You have to do a rotating internship and there aren't enough slots for you. Find them." So they came to the DMEs and the hospitals and the colleges and said, "Hey, you're turning out the students. Find a place to put them." People around town, when they heard this kind of stuff, came to me, and I ran into a little bit of trouble with Metropolitan and Parkview doing St. Mary's and St. Joseph's. I'll tell you this. They had three institutions. They had Tri-County, Met and Parkview at one time. They had a DME at each one, but the main DME was a guy by the name of Al Bonier. A real gentleman guy. So I called Al and I said, "Al, I need to do this. Is this a problem with you? I'm going to put maybe eight guys at St. Mary's. Is that going to bother your people? And St. Joseph's.



They're not too close to you to cause any troubles or anything?" He said, "No, no, no problem. It's great." So we start all the paperwork, we get it all going, and he calls me up about two months later and he says, "There's a problem." Archie Feinstein and Rick Anderson didn't like this, so Bonier calls me up and we have a meeting. He said, "We don't want you to do this." I said, "It's too late. I asked. You said, 'Yes.'" He said, "You can't do it." I said, "It's too late. I already gave my word to people. The paperwork is done. People are in, and there's too much work. I can't do it now. Maybe next year, if that's the case, if it's really that much trouble for you. I mean, I always told everybody I backed up on it. But I can't do it this year." Now they said, "We're going to raise all kind of Cain." And they did. They gave me more grief. Anderson tried to cause more havoc. But we made it. Because of those trial programs, the College was able to continue developing these kinds of things for our students. The Germantown issue --



that was not mine, but we started St. Agnes and St. Joseph's, as I said. There was a lot of opportunity there, without hurting anybody else.

CBP: Graduate education in the mid-1980s, as far as residencies -- not internships. What was happening with the demand for residency training, and how was PCOM responding to that in that time period of the 1980s?

JD: Well, we had any number of them. I mean, you're talking about all the specialties now. Emergency room medicine was a new and flourishing residency program and the College really came on strong under Becher's expertise, and developed a tremendous residency. The Department of Medicine with Dr. Dickerson flourished. We developed other subspecialties. And the College was now doing what everybody was doing. All the departments were sending people out for a little more training here, just to round it out so you're not learning from one person. Bill Dickerson did infectious diseases. He sent his people here and there. We had nephrology,



pulmonology, G.I. We had all these subspecialties, and Tom Rowland kept hiring full-time people. We had this great faculty. So I think the College responded. It knew its shortcomings. Each director knew its shortcomings, and made sure its people got a little bit more here, a little rotation over there, rotation over here, to fill in the gaps. I think because of that we developed a tremendous cadre of people who had now -- a real good feeling about their school. Things were really moving. The Hospital was full. It was great. The Hospital financially, though, was losing because of the DRG issue, and probably because of the teaching issue. So there was a lot of consternation about how to handle this thing. We got two hundred fifty students to teach in each class. There's four hundred and thirty of them wandering around someplace. So we have all these out rotations now, the first one of which took place when I was a senior. So they're all over God's creation. We now have clinics all over the State of Pennsylvania. We



only had the two. We now have residents all over the place. They didn't go anywhere in those days. So you see this tremendous amount of growth. You now have full-time faculty, which we didn't have. You've got about eighty full-time people. It was just great. A good group of people. But then the financial issues started, and that started creating problems. Plus, our hospital -- I mean, let's face it. Our hospital was not Jefferson. It was small. I think we made up for our smallness with great teaching and conferences. We had daily conferences that were started way back when and I started to continue. Archie Feinstein was our DME way back when. We tried to continue a daily conference and we had it very organized when I was DME, so that we had the residents participating and attendees. There was a lot going on. It was really going strong.

CBP: You served as Dean from 1985 to 1989, a period which could be characterized by hard financial times for PCOM. Please comment upon the difficulties the



College and Hospital were facing, including the drop in admissions applications.

JD: Well, the College was doing well, financially. The College didn't have a problem. The College had excess monies. The Hospital was terribly affected by this time. The last year I was there, they deferred three million dollars to the Hospital to balance its budget, which I wasn't happy about. Dr. Tilley, our President, clearly anointed me the advocate for the College. He said, "I want you to continue doing what you're doing," meaning standing up and fighting for the dollars for the College. I said, "Okay, I'll do that." I would present a budget after meeting with all the department chairs, and I would present this budget and it would come back to me from finance and say, "You need to cut a half a million dollars." I'd say, "I already cut what I need to cut." They'd say, "Cut some more." I'd say, "I don't know if I can." So they cut it, or they put things on hold and just took the money. No question, they were tough times because the



Hospital had all these residencies that people were debating about graduate medical education and the government funding for it. The faculty practice plan was brought into fruition about that time. We were trying to look for a way to bring more dollars into the institution and faculties in most academic places were developing these practice plans where they were allowed to function more like private practitioners with an academic link rather than just academics.

CBP: Clinical Associates?

JD: Right. Of which I was chair from its inception. There's no question that they were rocky times. And that's when the institution re-did its structure into a foundation and five subsidiaries. We had the College, the Hospital, the Faculty Practice Plan, Management Services. And something else. There was another one -- a for-profit entity of some sort. But anyway, the drop in admissions was not something that was PCOM specific.

CBP: Was it a drop in applications?



JD: Yes. A drop in applications. It was not PCOM specific -- it was across the board. Remember that in the early 1980s, the stock market was doing well and investment banking was going through the roof and there were all these young turks on Wall Street who were making a half a million dollars with their MBAs. I remember talking to Carol Fox. She would go out to different colleges and they would have booths set-up for college students to come in and look at different professions and so on. She said the MBA booths were like twenty deep. Medical school booths were -- there was nobody there. Everybody was looking for their MBA. They all wanted to go to Wall Street. Banking and so on and so forth. So that that was a reflection of that. And as a consequence, we were trying to look for ways of increasing our student application pool, and we had talked about having the admissions office go out and develop scholarship programs with small states in the South that didn't know much about osteopathic medicine, but needed primary care



physicians. Well, why don't you fund three slots for residents from your state who will come back and practice? Why don't you go to Arkansas? Why not go here? So we were about ready to start some of that stuff so that we could get -- you know, if you got ten or twenty funded seats, you had ten or twenty students that were guaranteed from that state. They had scholarships, as long as they went back there and practiced. And that was something we had in mind. I started the Minority Student Scholarship Fund so we could help more minority students get to school. We had a lot of things going to boost our application pool. I started the MBA program. The old program was St. Joseph's. We started to scratch the surface with the D.O. and P.H. program at Temple. I thought they were good, since they were things that were necessary. I just read an article the other day about an MBA program, like it was this new and different thing. We've had it for how many years now? Ten years? I just read it in some journal. But that was something that clicked



beautifully, that really went nicely. I had three programs I wanted to do for combined degrees. I wanted to do the D.O. and P.H., the D.O. MBA and the D.O. Ph.D. The MBA came across without a hitch. The P.H. was on its way. And the Ph.D. -- we didn't have enough time to get the Ph.D., but I thought it would take a little more time to get this going.

CBP: A Ph.D. in what?

JD: Whatever they wanted.

CBP: Research?

JD: Basic science. You see, I wanted to bolster research, too, which was something we sorely needed. So I thought if we could get guys interested in research, that they could come in, into a D.O., Ph.D. program. Maybe a student who already had a Master's program, or didn't, but wanted to. We couldn't get them the Ph.D. within the four years of PCOM when they were a D.O. But I thought if we could get them where they only needed X numbers of credits and/or their dissertation, with an affiliation with somebody who had a graduate



program. So we had those kinds of programs that made us more attractive, I hoped, to the applicant pool that was, again, falling all over the place. Then, of course, there was the great crash of October, and all these wizards on Wall Street were flopping around and suddenly, the applicant pool came back again. It amazes me in today's world, with managed care. But I think in most people's eyes, it's a job. You may not make what you used to make, but it's a job, and it's a good job. And if you like medicine, it's a wonderful job.

CBP: Please comment upon the efforts of President Tilley and the Board of Trustees in addressing the struggles of the 1980s -- the financial struggles -- including the \$22.9 million bond issue of 1988.

JD: The institution, I think, is large, but with our foundation, not as large as some of the older institutions in Philadelphia. There was great concern about our debts and our continued existence with the Hospital, so that this bond issue -- actually, I had a lot of questions. I think



everybody did. I guess the main question was, "Is the College at risk?" That was everybody's concern. Everybody was guaranteed that it was not at risk. And to be honest, I'm not sure if that's true. Herb Bolton did put this together. Anyway, it came to fruition. I guess it wasn't too much longer after that that I left. I had some questions about that bond issue that I shared with Dr. Tilley. Again, about the College and why the money was going from the College to the Hospital. The whole practice plan issue was really something that caused a riff between Herb Bolton and I. There was lots going on in those days in the last year that I was at the College. We had all these programs going, and created this thing with Wilkes College. An accelerated program, which was a new thing. We wanted to do more of them if we could. Again, you were talking about admissions dropping and things like that. It was an accelerated program with Wilkes College -- did you know that?

CBP: Yes, that was one of my next questions. It started



in 1988, a seven-year B.S. D.O. degree.

JD: Yes.

CBP: Why was that program developed and what became of it?

JD: Well, I don't know. It was gone when I left.

[laughs] Actually, I wanted to do more. In answer to your question about what was happening with the decreased application pool was what I told you. I'm sure because it had to do with the economics of medicine and the world in general at the time. The best and the brightest were looking for financial jobs in banking on Wall Street, because that's where all the big money happened to be at the time. So we were looking for ways to make PCOM more attractive, and we had a million great things going. It was the MBA program, and they were looking to do a D.O. almost-Ph.D. program. We had the Minority Student Scholarships Fund. I had a whole community at the College for computer orientation and computer teaching. Then the small states thing I was looking for to see if we could get designated seats -- three



of them. And our choice, of course, but a student had to be qualified. But paid for by the states. And then I wanted to get some accelerated programs going, where this would all bolster our application pool. The accelerated program actually saved the student a year of education, instead of eight years. First of all, it was only set aside for the best and the brightest of the other graduate students at Wilkes. They did two years, and they had all kinds of psychological evaluations to be sure they could do this. I forget all the details of it. I remember meeting with them at Wilkes for years.

CBP: If this was seven-year program, when would they come on to the PCOM campus to start their medical courses?

JD: I think it was after the third year. They would do some basic sciences combined, so to get their Bachelor's degree in retrospect, and their D.O. degree forward.

CBP: Why Wilkes College? I mean, with all the colleges that are even --



JD: Close by? Well, actually, because they had experience with a program like this. They had apparently done something like that with Hahnemann. It wasn't my brainchild, that's for sure. But it was something I knew existed before in other institutions. It was something that we really hadn't gotten to, but it came to me, I think, through Carol Fox, through this physician up there. So met with him and met with him, and we went up to Wilkes and we talked to them for a while.

CBP: How many were you taking in a year?

JD: We hadn't even started yet. I mean, it was done -- it was signed -- but nobody went on campus until after I was gone, so I don't know what happened. It was just like the Minority Student Scholarship. I got a call five years after I was gone from the College and wanted to know what happened to it. I said, "What are you asking me for? I have no idea what happened to it." [laughs] But anyway, back to your bond issue. This era became -- I think this was the beginning of the downfall. I'm not saying



we should have never gotten rid of the Hospital. I'm not. I won't say that because I think it was probably inevitable. Because the osteopathic hospitals in Philadelphia were such that they would probably never have gotten together to save themselves, so they all went down individually. Not all of them. They're still some existing. But rather than get together and work on a plan, they killed each other off. But there were a lot of political shenanigans going on. Tom Rowland was sick. There were all kinds of rumors going around. Tom Rowland died, and a bunch of the faculty -- I was DME, remember, at the time -- acting, or whatever I was. And still Chairman of the Department of Peds. A bunch of the young faculty came to me and asked me if I would consider being President. I said, "Only with your support. If I would think of it, I want you to support me to the hilt, because it's not going to be easy." Yeah, yeah, yeah.

CBP: This is before Tilley was there?



JD: Oh, yes. I'm not going to pull any punches here, all right? You can print what you want -- I don't really care. Tilley was nothing at the College. He was a good radiologist, but he didn't participate in College activities. But he happened to fall into the Chairmanship of the staff. He had been Secretary or Sergeant in Arms. Parliamentarian -- that's what he was. So he read the Bylaws and knew them all. Nobody else really cared. So when there was a question, Pete Tilley had the answer. After Tom died and there was a Chairman of the Staff election, he was elected. Fine. There was all this maneuvering on the chess board happening. Ginny Thompson, who was Tom Rowland's right-hand person for eons -- I remember her as a staff nurse when I was a student. We grew up in the same neighborhood. Ginny is now Vice President of Operations or something like that. So she's running the show. Well, a lot of the D.O.s were upset because they thought that maybe she was being hand-picked by the Judge to be put in that spot. The Judge announces



that she's going to stay in there until they put together a search. There's all kinds of rumblings, as usual. Nobody liked the Judge -- I don't know why. The next thing you know, Ginny's fired. I had had a meeting with her. I went in and talked to her, actually. I said, "Ginny, I don't know if you need any help. A large segment of the faculty has asked me to come to let you know we're here to help you." She said, "No, that's not necessary."

CBP: Who fired her?

JD: The Judge. That's my impression. I mean, there's nobody else to fire, but him.

CBP: She didn't just resign?

JD: Well, I got the impression she got fired -- was forced to go. I don't know this -- ask Ginny. But there's a woman who knows a lot of history, if you can get to her. [laughs] Really. She's been there for a long, long, long time. Interesting -- her words were something like, "There is a consortium here," or some sort like that. I said, "Oh, interesting." That's all she said. I couldn't pick



anymore out of her about what that meant. But there was a group that was trying to, I guess, manipulate who took over after Tom, for whatever reason -- no clue. Anyway, Ginny leaves. So because Pete is in this position, I guess the Judge talks to him -- he takes over. Meanwhile, the search is going on, and I called the Judge when he was on campus one time. I was really uncomfortable with this. I said to the Judge, "I want you to know I'm going to apply for the Presidency." He said, "Well, that's wonderful." [laughs] I said, "Tom was a very, very good friend, and I really feel funny doing that. Some of the faculty had asked me to to this, and I think I have some support for this." He said, "Well, that's great. We need as many applicants as we can get." So this goes on for a while, and I send him this big dossier. I knew who the other applicants were. Pete Tilley called me in one time and he said, "I want you to know something. I want you to know that the Judge tells me that nobody from inside is going to get this job, but me, and I don't want it. So it



will be his choice for somebody from outside, unless I take it from inside. But it doesn't mean you shouldn't keep going. Maybe it will change. But if I have to take this job, will you be Dean?" Now, being a little bit street-smart, I don't know whether this was a bone he was throwing me to get me out of the way, or whether he was telling me the truth, and that we would do this together. I said, "I don't know. I'd have to consider that." I had a great deal of support for the profession, and a great deal of support from within the institution. We went through this whole thing. To the day of the interviews, Tilley never put in an application, and he became President. Because the Judge manipulated it. Tilley's words to me -- honest to God -- "The Judge thinks I'm malleable." I said, "Well, we can do this together maybe. We'll see how it goes -- what happens." So he got the job. He was in there for a while, and then somewhere around 1984, I guess -- I was acting Dean for a while -- for about six or seven months -- he dismissed Dean England somewhere



over the Christmas holiday. [laughs] Nice. Merry Christmas. [laughs] Dean England was a nice man. So I took over that. So that's where that put us. There was all these shenanigans going on. So Ginny's off campus, and then we split up into all these boards, and all these new Board people started showing up. I said, "Pete, what's going on?" I said, "You have to be a politician in this stuff." I wanted to be an academic, and that's what I really wanted to do, and help the College. But, you know, you've got to be careful of your back, no matter what you do. I said to him, "Your Board is being loaded with people who aren't your people." He asked me -- there were some openings. I said, "How about Bill Mann, head of the Republican Party in Philadelphia? How about this guy? How about this guy?" I had a lot of contacts. So he took them to the Judge for approval. I said, "What did you do that for?" The Judge blew him out of the water. Well, Bill Mann eventually got on one of the boards. But the Judge wanted to manipulate it. I said,



"You're losing control." I thought that Pete and I could talk. We did. The next thing you know, Herb Bolden gets crammed down his throat. There was no search for this guy that I knew of. He was nothing. He just was planted on Pete. Bolden was obvious in his disregard for Pete's authority. Obvious. Pete had Friday morning administrative meetings at eight o'clock. His administrative cadre came together. Bolden had one at seven. He would invite me, I said. Fine. I answer to the President. He would do all this stuff here and then he'd come here and he'd sit and flip through papers. I mean, it was ridiculous. He was the Chief Financial Officer for the Clinical Associates. We would have a board meeting and he would have poor Ed Bogeyman, who was the Controller, give the report. Guys would be all fired up -- he'd be asking questions. I'd say, "Why don't we have Mr. Bolden comment." The report's been given. I disliked this man a great deal, and he knew it -- no question about it. There was a major battle going on here and Tilley was being



pushed this way. Every two months there was a new corporate structure -- reporting structure. If you go through, you'll see this reporting structure. It keeps changing. Everything was being moved over to Bolden. Bolden wanted to run the Hospital for a while, so he got the man he wanted in there. He wanted to run Clinical Associates. We didn't want him.

CBP: If all this is happening, who really came up with the idea to sell the Hospital? Was it Tilley or was it coming out of the Judge and the Board?

JD: Well, I was gone then. Pete called me in in September -- September 26, 1988 -- and said, "The Judge is taking pot shots at us." I said, "For what?" He said, "Well, we're not cooperating with Herb." I said, "Wow. How come?" I said, "We're doing what you told us to do." I mean, I'm doing what he told me to. When he wants to cut money from the College I stand up and say, "Why?" I said, "Well, what's he doing with it? He shouldn't be involved in that kind of stuff." He said, "I just



wanted to let you know." So a board meeting comes -  
- College Board. Actually, the faculty is up in  
arms. They're up in arms about everything that is  
going on, with Herb Bolden taking over. We fire the  
Executive Director of Clinical Associates. He gets  
fired. Bolden wants to run it. Nobody wants him to  
run it. They say, "No, we don't want him to run it.  
It's only us." So Bolden is going to take care of  
it. They were just unilateral decisions being made  
by him. The writing was clear. A group of faculty  
-- Chairmen -- had a meeting at a faculty member's  
home on a Sunday night, and they asked me if I would  
attend and I said, "This is dangerous territory." I  
said, "I'm a member of the administration, too."  
They said, "We know, but you're also Chairman of  
Clinical Associates, and you're one of us." I said,  
"Okay, I'll go." I said, "But my meeting with  
Tilley is on Wednesday." I had a meeting every  
Wednesday with Tilley. So we met and they  
unequivocally said, "We're going to tell Pete that  
we don't want Bolden. That we'll support him if he



fighters what's going on, and that he needs to know that we will get our own attorneys if we're going to do Clinical Associates, and so on and so forth.

CBP: Was anybody in particular leading this group of faculty members?

JD: No, I don't think so. I'm trying to think who was even there. I think John Winn, John Becher. Dan Wisely was there. Ted Mauer. On Wednesday I told Pete. I said, "Pete, I have to tell you this. There was a meeting the other night. Everybody wants to support you. They invited me there to be the conduit to you. They want to sit and meet with you and tell you what their concerns are." He said, "Okay." I guess that was the middle of October. I went away to a meeting, came back October 19th. We had a College Board meeting, and there was all this stuff going on. The Wilkes program, the MBA Ph.D. I mean, rave reviews at this meeting. And I actually met with the Chairman of the College Board, who was Dr. Herman Kohn, and I told the Vice Chairman of the Board, Ruth Purdy, in confidence --



I called them after Pete's warning to me of what was going on. I said, "Look, I don't know what's happening, but you two need to know. I'm not asking you for protection. I'm not asking for anything. I'm just telling you what I've been told. There's something happening. You are my Board Chair and Vice Chairman." Ruth Purdy said to me, "I know Dr. Tilley. Pete told us there were some things with you and Herb, but he told me that if it came to a showdown, he would support the Deanship -- you." I said, "Oh, wow. Well, that's nice to know."

[end of side two, tape one]

CBP: This is a discussion about the Board.

JD: Yes, the Board. I guess we were up to a board meeting coming up, and the board meeting went great. Things seemed to be flowing along pretty good. Obviously there was a little bit of apprehension on my part. That was on a Wednesday, and on that Friday, October 21, Pete Tilley called me in and



said he had tried to save me but couldn't. I said, "Well, that's all right. I'm not worried about it. I'm disappointed because this has been my life and I enjoyed the College, and I think we were making great strides and had a great deal of direction, though it was going to be rocky times for a while. But I told him that I wasn't worrying more about me because I thought I'd land on my feet, no matter what happened. But I also told him that there was no question that we needed strong financial guidance through these times, and I told him in no uncertain terms that I thought he had the wrong person in Herb Bolden, that he was going to destroy everything that was set-up with the school. The faculty had no respect for him. In my opinion, he was the demise of the faculty practice plan, rather than helping it survive. Every turn of the road he was a problem. The faculty didn't like him. And sure enough, I told him -- actually, I told Pete that I'd give him two years for the institution to survive, if it continued with this man. Actually, in my opinion,



Herb Bolden was running the institution, and I think that he had been anointed by the Judge. The Judge obviously had to be doing some politicking because I had a lot of good friends -- people on the Board who supported me a great deal. So something had to get Herb Bolden enough power to make that happen. And he actually told people who really despised him, "I can do anything I want." With that -- in March of the following year -- the faculty practice plan was disbanded. You have to understand, this is a group of eighty physicians -- full-time physicians -- from surgeons to orthopedic surgeons to neurologists and pulmonologists and pediatricians and neonatologists and E.R. doctors. All these people -- eighty doctors -- the private sector never liked the whole-time people. There was always that little conflict, particularly Galen. Galen always had this misinformation. I heard him stand up at a meeting and say, "The faculty practice plan failed once before. We should be careful." Galen has no idea what he's talking about. It didn't fail. It was



made to fail. The books were cooked and it was made to fail because people would not allow it to succeed. When you take eighty full-time people and you pay them an average of eighty-two thousand dollars a year, you tell me how many private sector positions make that kind of money who work the kind of time. They were always saying, "Oh, you guys get a paycheck every Friday, this is easy, that's easy. You get this, you get that." Who did all the teaching? Who took care of all the patients? I mean, they took care of just as many patients.

CBP: I'm confused about something. Tilley started the Clinical Associates. Is that correct?

JD: Tilley didn't. It was started during his reign.

CBP: That's what I mean. During his time it was started, but it was also during his time that it was disbanded?

JD: Right. The whole-time faculty concept was started by Tom Rowland. But putting them together as an entity to make more money, to give them an incentive -- it was a program to incentivize the faculty, to



allow them to make more money by doing more work. By creating new interface with the public -- practice -- whatever. Because that was the way things were going. When I look back today -- if they had eighty clinicians today to bargain with managed care companies -- wow! It would have been the thing to do. But it was disbanded. I don't know where Bolden's head was. It was disbanded, so you lost all the whole-time faculty, except for a handful which you have left now, or they were bought back or whatever. But I talk to the students. People don't show up in class, like when I went to school. It went backwards. And we lost the Hospital, and I'm not saying that's secondary to anybody doing something wrong. That might have been something that was going to happen, it was inevitable -- whatever. It would have been very difficult to support that, considering that in 1988 or 1989 -- whatever the last budget year that I was there -- 1988, I guess -- we gave the Hospital three million dollars. That's a lot of money. So the



successes of this College are because of the students. They're there, and the money they pay. They were the political things that I saw happen during those times, and I remember getting calls after I left asking whether I would serve on a watchdog committee for this and that. I really felt bad about what happened at the College, particularly the disbanding of this faculty -- people who dedicated their careers to time and effort. I'm sure it was done because people thought it was the best thing to do. But it wasn't.

CBP: In 1987 the Bone and Joint Diagnostic Center of the Musculoskeletal Institute was established, and then one year later, the Center for Rehabilitation Sciences. Please describe the nature and relationships between these entities, including the Musculoskeletal Institute, and what became of this program.

JD: Well, they were in the formative stages when I was at the College. We were talking about taking over the floor and melding it -- now that you refreshed



my memory -- and blending it, I guess, into rehab and osteopathic manipulative therapy and orthopedics and physical medicine and rehabilitation, because obviously, the musculoskeletal system is our strength. The object was to blend this group together and dress it up and make it the Musculoskeletal Center in the city. There were a lot of thoughts like that that were flowing through. An "Executive Express Center," too, I think it was called. Something along those lines, where an executive could come in and get a complete physical in a day and go through it, from one end to the other, and get everything checked. So there were all these things that were floating around at those times. When we were reaching, we were reaching for things to help those deficits. We were talking about changing the campus around and fixing this and doing that. Some of it was glitz -- dressing it up -- but some of it was a reach for what we thought we did best. That's all I can remember about that.

CBP: Do you know what became of the Musculoskeletal



Institute?

JD: No, I have no idea. When I left it was going, I guess. It was starting. I don't know what happened to it.

CBP: Over time, would you say that you personally have used OMT more, less or the same in treating your patients?

JD: I use it the same. I have to tell you this interesting story. I had an applicant that I knew and recommended to the College. He doesn't remember the name, but there was some 'old guy,' as he said who was on the committee, and they were asking this young applicant about osteopathic therapy, and the applicant said, "Oh, yeah. I know about it. Dr. Dieterle told me about it, and Dr. Jacobson told me about it." This old person said, "Well, he doesn't use it anyway." I don't know who this person is. They have no clue what I do. Everything I have ever done in osteopathic medicine -- pediatrics -- has included the musculoskeletal system. I gave a treatment when that student was here. I don't treat



every patient in the office when they come through here. I use it as a therapeutic modality. I always have. My evaluation from the newborn to the adolescent -- there's a musculoskeletal examination in every one of my patients, from the newborn to the adolescent. Anybody who says any differently is wrong.

CBP: How would you characterize the trend in using OMT in pediatrics within the osteopathic profession, in general?

JD: I don't know. I don't know what my peers do. I know everybody in this office uses it when it's indicated. We have five osteopathic pediatricians in this office. Probably one of the biggest, if not the biggest, D.O. pediatric practice in the nation. And I know we all use it. We use it on each other! I can't comment on how it's used across the board. The majority of osteopathic pediatricians are now trained in allopathic institutions. We only have a handful of residencies that exist anymore. And it all goes back to these financial constraints of the



early to mid-1980s, and the power that the financial people had for their demise. You know, you can always keep a program going if somebody is willing to support it. We were educational institutions, where the financial people took over for survival. But now that the College is so well-endowed, maybe they ought to think about supporting some residencies in the post-graduate arena. But there's no place to train them in our profession. I mean, almost no place. Almost every residency today is affiliated with a large MD institution.

CBP: Well, if these osteopathic medical students are not going to get this reinforced at a graduate level, where are they going to do it, and can they even do this in an allopathic institution?

JD: Oh, yes. There are probably about a hundred and fifty D.O.s training right now in allopathic institutions. Some of the best institutions in the United States.

CBP: Are those allopathic institutions letting the D.O.s practice as D.O.s?



JD: Well, I don't know. I can't comment on them.

CBP: Are they doing OMT that they learned at PCOM -- are they doing that in St. Christopher's?

JD: I can tell you that twenty-five years ago, when I was at St. Christopher's, despite what some of the older D.O.s have said who don't know, is that when I was at St. Christopher's, I did osteopathic therapy. I did a skeletal exam. I was recognized for my ability to do musculoskeletal evaluations. I found things that my peers didn't find. I did OMT on my allopathic compatriots. I sent attendings to PCOM for treatment, despite what the older guys think about me and my allopathic training. They have no idea what I do. I've told you that all my family has been treated at PCOM, and surgerized, and everything else, and the people I've sent there, and the M.D.s I've sent there, and the M.D.s I've treated. The pathology -- I never hid my D.O. degree. There was never any reason to do that. I stood up for my profession at St. Christopher's, and I'm proud of it. And I think I took my profession



to that institution, and I said, "This is what a D.O. can do." And that's a credit to my institution and to all the people who taught me, and even those who disparaged the fact that I went to St. Christopher's.

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

JD: I think they have been a leader in the profession, as far as I'm concerned, in regards to innovative activities. I think that we missed the boat in the mid-1980s a little bit. We were so busy protecting our flanks financially that we missed the boat for some other growth parameters. But suffice it to say, we've turned out some of the best students. We've had some of the best innovative basic science programs, and the outside internship programs. I think we've been a leader in our profession, and turned out some of the finest physicians in the profession.

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



the 21st century?

JD: Well, I think in a nutshell, PCOM needs to continue to turn out a well-rounded primary care physician. I think that's still where our forte is. But this physician needs to be well-versed in the intricacies of the practice of medicine, including the business aspects of medicine. They need to be well-versed in the managed care aspects of medicine, the political aspects of what's going on, unfortunately. The College needs to continue its development of computer enhancement of the educational process. The computerization of the medical record in the office, as well as in the hospital. It needs to prepare a physician for those who do not want to go into primary care to be ready and well-versed in the subspecialties in medicine, and it would be helpful if they turned out physicians who were more interested -- at least some physicians -- in research. And they need to continue their emphasis on osteopathic manipulative therapy. I think that our background in anatomy and our background in



physiology, coupled with our knowledge of structure and function is absolutely important. If we don't lose sight of that, I think we're on the right track.

CBP: That's it for my prepared questions.

JD: [laughs] Gee, is that all? [laughs] We've covered the bases for you.

CBP: Thank you very much.

End of Interview



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