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Leonard H. Finkelstein Oral History

Philadelphia College of Osteopathic Medicine

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INTERVIEW WITH LEONARD H. FINKELSTEIN, D.O. (CLASS OF 1959)
PRESIDENT AND CHIEF EXECUTIVE OFFICER
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
September 30, 1996

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

FINKELSTEIN:

CBP: Where do you currently reside?

LF:

CBP: Sure.

LF:

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

LF: I grew up in my father's pharmacy so I was exposed to physicians early on. I started working when I was eight-years-old dusting shelves. I became familiar with many physicians who would come into the drug store for whatever reason. I really didn't have any awareness of osteopathy in the earlier years. My first experience, which probably resulted in my decision to come to PCO, was when I had an athletic injury resulting in a dislocated meniscus in my knee. My family doctor at the time was an M.D. He was unable to do anything other than tell me to put hot packs on. He sent me to another doctor, who told me to put ice on it. In the meantime, my knee was in a locked position for about

three or four days. I had a cousin at the time who was a fourth-year student at what was then PCO, at 48th and Spruce.

CBP: What was his name?

LF: His name is Hartley Steinsnyder, who happened to become a urologist. He was one of my trainers and became my first associate when I went in to practice. I went to see him. He was a fourth-year student in the clinic at 48th and Spruce, in the basement of the building at the time. And he, as a fourth-year student, manipulated my knee, and the meniscus went back into normal position. I walked home, having had to get there on a crutch because I could not straighten my leg. That was my first realization that osteopathic physicians possibly were even better or could do more than their M.D. counterparts. I also, because of growing up in the drug store, became involved with prescription-filling early on. I would count the pills and work with my father in the back. I would see prescriptions coming from osteopathic physicians, and knew that that part of the practice was very similar. I became aware that it was a complete form of medicine probably when I was in high school.

CBP: Where was the drug store?

LF: The drug store was at 49th and Chester Avenue in

West Philadelphia. My father owned that store from the early 1940s through 1955.

CBP: I understand that you are part of a family of osteopathic physicians. Could you tell me about the other Dr. Finkelsteins?

LF: Well, my three children are all graduates of PCOM. Larry, my oldest, and Lisa, our middle child, graduated and were in the Class of 1987, and Robert, our youngest, was in the Class of 1990

CBP: Are they all practicing locally?

LF: Our son, Larry, is working with the College in the Department of Family Practice. My daughter Lisa happens to be a urologist, as I am. She practices in Michigan. Her husband, Marc Domskey, is also a graduate of PCOM. He graduated in 1986. Marc is an anesthesiologist and Chief of Anesthesia at Mount Clemens Hospital in Mount Clemens, Michigan, which is an osteopathic hospital. That's about the extent of the profession in the immediate family.

CBP: Where is the youngest one right now?

LF: The youngest, Robert, is doing dermatology residency here at the College. He served a family practice residency and is board certified in family practice, and he will complete his dermatology program in June of 1997.

CBP: What college education had you received prior to

matriculating at PCOM?

LF: Well, I was sort of stuck in West Philadelphia. I went to elementary, middle school and high school in West Philadelphia -- West Philadelphia High School. Then I went to Philadelphia College of Pharmacy and Science. My Bachelor's Degree was in pharmacy. And then, from there, I went to PCO. I could walk to every school I went to from kindergarten through medical school.

CBP: Why were so many pharmacy students attracted to osteopathic medicine and PCOM?

LF: The reason, I guess, is that many pharmacists were motivated to be physicians. I know that in my time that was the case. Pharmacy, for me, was -- if I could not get into medical school -- a way to make a living. I knew my father's drug store was there for me, so that it was sort of a back-up if I couldn't get into medical school. Back in the 1950s and 1960s, it was very, very difficult to get into medical school. The number of applicants was way above the number of positions available. So I think it was for that reason. In my class, I believe, there was well over thirty pharmacists out of less than ninety students, so there were large numbers of pharmacists in our classes in those days. I believe the Class of 2000 has maybe eight to ten pharmacy

graduates in it.

CBP: To your knowledge were pharmacy students drawn anymore to an osteopathic medical education versus an allopathic medical education?

LF: In my time, absolutely, and the reason was simply the fact that the other medical schools would not accept pharmacy degrees. If it wasn't a pre-med degree with a more liberal background -- liberal arts background -- they weren't considered. In my time, the only school in the Philadelphia area that accepted a few was Jefferson, and the fact is that I was put on a wait list at Jefferson, and was accepted for the following year. It was my feeling that it didn't make sense to waste a year of my life, when I could move right into PCO. That was the basis of my decision to come here, versus Jefferson.

CBP: What were the highlights of your educational experience at PCOM in the 1950s? Courses, professors, things along that line.

LF: Well, of course, the unique experience and the most profound for all of us during those days was the presence of Angus Cathie, the Professor of Anatomy. I'm not sure whether anybody else that you've interviewed has mentioned that yet, but he was a very, very dominant individual, and created a

lasting impression on, I think, almost every one of us. There isn't any one of my classmates or any other graduate since that time, that if you were to ask, "Who made the greatest impression?" it would probably have been him. He was a very accomplished anatomist. He was a very accomplished manipulating physician, he could move every bone in your body without even blinking, and without even creating discomfort. A strict disciplinarian, he was a very rigid and unyielding kind of person, but he is the most memorable event of that time. [laughs] I think the thing that was most exciting for us was to learn early on manipulative medicine. Our counterparts in the allopathic schools never touched the patient, and never did anything that was therapeutic until they reached the clinical year, which was usually the end of the third year. We started working on ourselves, learning manipulative medicine, then practiced on our family and friends. We were able to accomplish things early on, as we were developing as new all-around physicians.

CBP: How early on did you start doing that hands-on OMT?

LF: We started to practice probably during the first week of school.

CBP: This is before having a background in anatomy?

LF: Well, as the anatomy was developing, so were the

courses in manipulative medicine. OPP, they were called at the time. We practiced OMT, and it was sort of intertwined -- anatomy and the manipulation. The fraternities were a very important part of the training in those days. Fraternity houses served as practice sites. The alumni who were fraternity brothers would come into the house and teach us. The senior students would teach the junior students. That's how that worked. The course material was crammed in. We had many, many courses. During the first year anatomy and biochemistry and histology were dominant subjects. They were very difficult and demanding, and then when we went into the second and third year, the number of courses was almost overwhelming. In the third year alone, we had over twenty courses a trimester. That meant we had well over sixty examinations during the third year alone. In fact, when I finished, I was one of eleven in my entire class that got through without flunking an examination. I'm not sure whether that was because of my brilliance, or just sheer luck. I think it was the latter, probably. They were very difficult times. I worked my way through school as a pharmacist. I used to work three nights and every weekend.

CBP: Were you living at home while you were --?

LF: No. My father built and operated a new drug store in Brigantine, New Jersey. It opened in 1955, the year I started school, so I lived in Philadelphia, and my family had moved to Brigantine, New Jersey. I commuted from New Jersey for a short period of time, but for the most part I lived here, in an apartment around the school.

CBP: Was this student housing?

LF: No, we never had student housing. The school, to my knowledge at least, the time immediately before I entered, up until today, the school has never sponsored housing. There was always ample housing when PCOM was at 48th and Spruce, as there is now. The school has never had housing under its direction.

CBP: What about the fraternity houses?

LF: The fraternity houses -- all of them housed a number of students -- never many. I did stay for one of those years at the Log House.

CBP: Where was that located?

LF: I believe it was located about 45th and Locust Street. I'm not exactly sure of an exact address. There were probably about six of us that lived there when I was there, and I think that the other fraternity houses probably housed four, six, or

maybe eight students at any given time, and there were, I believe, three or four fraternities. You probably have a better count of that than I can remember.

CBP: In addition to the fraternity house being a place where you could practice your manipulative therapy, what other functions did fraternities provide during your time at PCO?

LF: Well, fraternities provided some recreation. There were social events that the fraternities sponsored. It was mostly a place where we could gather and talk about school work together and study together, and some socializing together. They weren't party fraternities as were traditional, and I guess still are, in undergraduate. There were meetings that were held regularly, and I remember Log had national conventions where the officers would be taken by the alumns. In fact, my first airplane flight was to California when Log had a national meeting there. I was Vice President of the fraternity at the time. I was treated to that entire trip by the alumni who were headed by Archie Feinstein, one of our all-time great local D.O.s. That was another fraternity function.

CBP: When and why did fraternity life begin to wane at

PCO?

LF: I can't answer that because it hadn't changed during the time when I was a student, and then I left to do my graduate education; I interned and did my general surgery at Zeiger Osteopathic Hospital in Detroit. When I came back to do my urology at PCO in 1961, I was just not involved with the fraternity so I really couldn't tell you. My guess is that as the school developed, there was less of a need for the activities that the fraternities got into. Also, what kept the fraternities together during the earlier days when I was involved, was the alumni -- the fraternity brothers who were out there practicing. There were large numbers -- at least in Log -- and I believe in the other two or three fraternities, it was the same. There was a cadre of graduate members who would come in and work with the undergraduates. And I think that that probably started to wane, and when that started to wane, the undergraduate interest started to go with it.

CBP: How about today? What is the status of fraternities?

LF: I'm not sure. I try to attend the Log induction meetings. I usually do. I probably have been to four of the last six. They seem to have a

significant number of students who come in, based on the notice that I see tacked on the walls on occasion. The fraternities are still involved in educational activities. I would assume they still participate in some way with manipulative medicine activities. But I'm not active in a way that I would know what's going on, really.

CBP: Where is Log now physically located?

LF: I believe it's in Wynnefield. I have never been there. It was, I believe, a purchase that was initiated through Archie Feinstein, who remained, I guess, the leader of Log until he died. Archie's dead about three or four years.

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

LF: Well, we were busy. We weren't overwhelmed with patients, but there were enough patients that we felt that every day we had our share of medical involvement dealing with patients. I remember not liking the professors or instructors -- at least the lead instructor. What was his name? Theodore? I'll have to look at the catalog. None of us really liked that fellow. Actually, I think that a lot of the faculty during our time -- and for quite a while were really dedicated to [making us angry]. There

were many angry students during those days.

CBP: Why was this antagonism going on?

LF: Well, I'm not sure. Maybe it was just the mode of medical teaching of the day, where the professors or assistant professors, instructors, felt they had to be domineering and controlling and whatever. That, obviously, was not all of them. But there was a fair number of them that were that way. You remember the ones that you got to dislike the most more than you remember those that you liked, I guess. One of the things that upset many, if not all of us, was the fact that the institution prohibited you from going to other sites for clinical training or education, even if it was on your time. A big event for us during those days was to go to Philadelphia General Hospital, which was the city hospital at the time. There was a tremendous amount of pathology. We were all hungry for clinical pathology. We felt we were restricted unfairly by being prohibited from going. We went anyway, but there was always the threat if we were found out that we could be suspended from school. That was not a very happy thought.

CBP: What was the basis of that policy?

LF: I'm not sure. You have to realize that back then --

it doesn't seem so long ago, we were looked at by the allopathic profession as quacks and cultists. We were really not in any way equal to them, in their eyes. In fact, it was unethical, according to AMA Code of Ethics, to receive a patient from an osteopathic physician for consultation. It was unethical for an allopathic physician to come to an osteopathic college to teach or lecture. So there was absolutely no good feeling, and I believe because of that, the administration of the College felt that there should be no association between us and the enemy. They literally were the enemy. We were still fighting to have full licensure in many of the states. I don't remember the number of states that were fully licensed when I was a student. It was the majority, but there were still a significant number that still had restricted licenses, where they could only manipulate. They could not write prescriptions. Some of them could not do surgery or deliver babies. The allopathic community in Philadelphia recognized us early on.

CBP: What else do you remember about working in the Clinic as a student? What were your responsibilities?

LF: Well, we were "boof" doctors, and we had our

patients, many of which had been coming for years. And what happened was when the new batch of students would hit the clinics, the students that were leaving would spend a day or so with us to show us the charts and give us a clue as to what we were supposed to do. There were two clinics back then. We had another hospital at 20th and Susquehanna, and we called it North Center. It was the old Women's Homeopathic Hospital that we had purchased probably in the very early 1950s.

CBP: It was 1951.

LF: Okay. You have to remember that we didn't touch a patient or see a patient until we finished three years of didactics. Today, students go clinical right after the end of their sophomore year, and that's the end of formal classes for them. So we had another full year of class work.

CBP: So you didn't even do it at the end of your third year?

LF: At the end of the third year is when we hit the clinics and the hospitals.

CBP: At the completion of the third year?

LF: Right. When we completed the third year. So the class was divided in four. One-quarter went to 48th Street Clinic; one-quarter went to 20th Street

Clinic; and one-quarter went to 48th Street Hospital, and one-quarter went to 20th Street Hospital. We spent three months in each place, and then we would switch, so that by the end of the year we all had the same experience, or at least the experience in the same sites. On my first day in clinic, right at the end of the third year, I wasn't in there twenty minutes and I received a stat call from the front desk. "Dr. Finkelstein stat." I just about knew what 'stat' meant at the time, but I knew I had to move. So I ran there and I told them who I was and asked what the problem was, and they said, "You have a patient who needs to see you right away." Standing in the middle of the hallway was this pregnant woman, with sweat pouring down her face and I said, "I'm Dr. Finkelstein. What can I do for you?" Her response was, "It's coming." Well, I never treated let alone delivered a pregnant woman. This was my first experience. I immediately picked up the phone, and paged the OB/GYN resident, who was in-house. That hospital was laid out in that the clinic and the hospital were in one building, and then across the courtyard was another building called the Sergeant Building.

CBP: Let me just clarify for a moment. We're talking

about North Center Hospital -- this experience?

LF: Yes. Clinic. First day in this clinic, and I'm confronted with my first patient ever, a pregnant woman in active labor. Pick up the phone and tell him that I have a patient in active labor and he said, "Put her in a wheelchair and take her to the Sergeant Building," which was where Obstetrics was, and that was across the courtyard. I said, "Okay, Mom. I'm going to put you in the chair." She said, "I'm not moving. It's coming." I picked up the phone and I called the resident back. I said, "She's not moving. It's coming." He said, "Put her in the damn chair and bring her over." I said, "You've got to get in the chair." She said, "I'm not moving. It's coming." And I believed her. I said, "How many babies have you had?" She said, "Ten." [laughs] I said, "Ten?" The closest room to us was a few feet from where she was standing -- it was the Urology Clinic. Nobody was in it, and it had an examining table. I took her in, I put her on the table, and I put her legs up just in time to catch this baby before it hit the floor. So here I am, first day -- first patient in my whole life -- and I'm holding a newborn baby with the umbilical cord and the placenta still in her uterus, wondering

what to do now. I had the nurse who came in with me pick up the phone and call the sucker who keeps telling me to bring her over. [laughs] Anyway, I clamped the cord, cut the cord, and finally we put her in a wheelchair and took her over to Obstetrics. But that was my first and most memorable event in my life, probably -- that particular day. First patient. First delivery. It was an exciting time. And we loved the patients. Some of our classmates went nuts, and they did things that they probably had no business doing. We had minimal supervision. We wrote prescriptions. All things were evaluated. We gave our treatments. The clinic at 20th Street was not busy as far as the number of patients. I learned how to play pinochle when I was in the clinic at 20th Street.

CBP: What kind of neighborhood was that, at the time?

LF: It was an all black neighborhood. They closed the emergency room before we got there. It was losing tons of money because it was twenty-four hours a day repairing knife and gun shot wounds. It was great if you liked doing trauma and things like that. Most of the cases in those days were not reimbursable, so they closed it. The clinic at 48th Street was busy, as far as the number of patients

that were there. One of the good things about the clinics was that they had specialty clinics scheduled all week long. If you had a patient with a urologic problem, the Urology Clinic was scheduled one day a week in each clinic. And if you had a patient with a cardiac problem, there was the cardiac clinic. There was a surgery clinic, and an OB/GYN clinic. We could follow our patients into the specialty clinics. It was terrific because there was a continuity of care. If we had a specialty problem, we would make note that our patient was there, and we made an effort to be there when the patient was examined. If it wasn't by the instructor or professor, it was the resident. That worked out very well for us.

CBP: Were you specifically assigned to a specialty clinic at any time?

LF: No, not on clinic service. In the clinic, our involvement with the specialty clinics was when our patients had a problem referable to that specialty, and we would then refer to that specialty. Then, unless there was a conflict timing-wise, we would be there for that. Also, if we had no patients of our own when one of the clinics was in session, we would be able to sit-in and observe the examination and

management of other patients. By the time three months had passed, needless to say, we were exposed to all of the major specialties. We had a fairly good clinical background. We never felt we saw enough patients. We never felt that we had enough hands-on. We were always starving for more. We always visualized the medical students from Penn and Jeff, making their rounds with their world-class teachers who wrote the textbooks that we used, walking through their sixteen- or twenty-bed wards with all the residents, as something more than we had. But when I started my internship after that full year, I felt that I was reasonably well prepared. I was fairly comfortable.

CBP: How did your experience in the hospital as a medical student, compare to your experience and responsibilities in the clinic?

LF: Well, the hospital was a lot more difficult. The clinic, if you didn't have a patient, you had some time where you could read or even play cards. The hospital was a constant grind. You had to come in early. By seven o'clock we had to be there. We also had to pick up blood. There were no lab technicians in the early morning or at nights. We had to do stat blood work, and we had to pick up the

blood ourselves. Probably the most memorable and distasteful practice was responsible for two or three generations of PCOM graduates -- leaning away from manipulative medicine. We had one professor who would write an order -- a surgeon -- to give OMT every ten minutes around the clock, and have a convulsion if we missed. It was oppressive. We had instructors that were on the floor to make sure that we gave OMT. It was almost like slave labor. I guess of all of the things in the hospital that we objected to the most, and which most of those in my time remember, was that oppressive policy of requiring the students to administer manipulative medicine to every patient in the hospital.

Sometimes in amounts that were totally unreasonable.

CBP: When did that practice stop, of having the students do that like that?

LF: Well, I would imagine it continued into the 1960s. I graduated in 1959. I came back in 1961 and I finished my residency in urology in 1963. I would imagine by the mid-1960s it was still being done, but it wasn't nearly as oppressive as it was when I was a student. When the hospital moved to City Avenue in 1967 -- it was never carried out to that degree. And then it went to the opposite extreme.

It almost disappeared.

CBP: Was this a common trend in the osteopathic profession, or was this something that was going on at PCO?

LF: What do you mean?

CBP: The degree to which you were doing OMT while you were a student, and then, by the time it was the mid-1960s and when the hospital moved over to City Avenue, that it considerably slowed down.

LF: You have to also remember that when I was a student, there were only six colleges in the country. And then in 1960 -- I believe it was 1960 -- we lost one of them. We lost the Los Angeles school, which was probably our largest. The Los Angeles school in 1960 -- the profession merged in California into one profession. There were a small number of D.O.s that maintained their D.O. degree back then -- maybe a couple hundred out of a couple thousand. You had the original school, which is in Kirksville, which, to this day, I think, emphasized manipulative medicine more than the others. And the others -- in varying degrees. I never really was exposed to the individual schools so it's difficult to compare the intensity of that training as it varied from school to school. You also have to keep in mind the

politics of the day, as far as the two professions were concerned. Where, as a student, as I mentioned, we were quacks and cultists in the eyes of the allopathic profession. That started to change as I was approaching my senior year, and soon after. In fact, the fact that the California professions merged was the first strong indication that the M.D.s finally realized that it didn't make sense to maintain that policy. There were also inspections by their people of our schools to see if we were indeed truly a credible school of medicine. And that was another interesting thing. Five schools allowed the allopathic people into evaluate them, and PCOM was the only one that would not let them in. I'm not sure what that meant to us. I don't think it hurt us significantly. I'm not sure it did us any good, either, but it was something that we talked about during that timeframe. The day that the allopath removed the quack and cultist label, and opened the doors for our physicians to refer their patients to them ethically -- on their side ethically -- and more important, to allow our physicians on the staffs of their hospitals -- was the day of great change in this part of the country, much to the detriment of the profession here and our

college in particular. Because of the feelings that many of us had due to the way we were treated as students -- I think I mentioned that earlier in the discussion -- many of our people just flocked to the allopathic hospitals. The allopathic physicians benefitted immediately by the large numbers of referrals to specialists, and so forth. And, of course, hospitals started to see their census grow because of the tremendous numbers of D.O.s that were joining their staffs. Also, we probably have to blame ourselves -- this college was very restrictive in its allocation of beds to D.O.s. The D.O.s couldn't admit to their own hospital; the hierarchy of the time controlled the hospital. In fact, up until the time I became a staff member, which was right after my residency, the staff at PCO had to buy their beds. They had to pay money to belong to the staff, and they had to pay for the beds. For example, Hartley Steinsnyder, who I became an associate of and a partner with early on -- he was allocated, and had to pay for one-half of the bed. That meant that he could have a half a patient in the hospital at any given time. And what he had to do, obviously, was with a friend of his who had a half a bed -- they would alternate their patients so

that they could have a whole patient in a bed. That was the reason some of the other hospitals were developing in this area. Metropolitan Hospital was formed because the Jewish doctors that had graduated from here felt that they could not get privileges and didn't have a hospital -- they started their own. A group of twenty of them formed a hospital in Delaware County. It was called Tri-County Hospital, of which my ex-partner was one. And that also resulted in the alienation of many of our graduates. They were angry. They couldn't get privileges. They couldn't admit their patients. The group of physicians that they felt abused them as students, controlled the hospital beds.

CBP: I have a question for you about Metropolitan, and it does come into this interview here. I'll ask it now. If PCO took in as many Jewish students as it did, compared to other medical schools, there was a very high Jewish population here?

LF: Yes.

CBP: Why did they not welcome them as well for staff privileges versus their having to go out and form this new hospital?

LF: Well, I believe there was anti-semitism, but they weren't stupid. They needed to fill their classes,

and there was a disproportionate number of Jewish applicants that wanted desperately to be physicians. I believe that that was the reason. But if you looked at the senior staff people, they were not Jewish. To my knowledge, there were two significant faculty people who were Jewish. One was Victor Fisher, who was a cardiologist and a premiere cardiologist at the time. In fact, he died of prostate cancer, and as a resident, I took care of him. And the other was Herman Kohn, who was in OB/GYN and also General Surgery. But that was basically it. I mean, there were others, but they were not on the Board of Trustees or department chairs to my knowledge. There may have been one. It was very difficult for them to achieve positions of significance in the College. Once they graduated it was very difficult for them to get -- of course, it was difficult for everybody, I guess. But as you said, there was a significantly higher percentage, at least in relationship to the other schools, and they had nowhere to go. So being an industrious, entrepreneurial, aggressive group, they formed their own hospital and that was Metropolitan.

CBP: There's just one or two other questions I want to ask you about your time as a student, and then we're

going to move forward. Were you on call when you were working in the hospitals?

LF: When we were in the hospital at nights, we slept in.

CBP: Where did you sleep?

LF: There were quarters at 48th Street, and at 20th Street there was a separate building that housed us when we were on. You had your nightshifts, so when you were on night shift, you didn't work during the day. So you were not on call.

CBP: So it wasn't like around-the-clock call, in terms of residents?

LF: No. When we were on hospital duty during the day, I think it was like seven-to-seven, and when we were on nights, it was seven-to-seven. When we were on nights, we would sleep in, and obviously, though, we were called off and on during the night for whatever reason, just as they are now. And I think that's the way it works now in the hospital. And when you're in the clinics, there were no nights and there was no call. If clinic patients had -- I don't remember what happened to clinic patients at night when they had a problem. I don't remember that. I know that I was never on call for clinic service.

CBP: Do you recall anything about an OB clinic at 3rd and

Lehigh?

LF: No, that was before my time.

CBP: But you have heard of that?

LF: Only since you've been here.

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

LF: Well, first of all, I had decided to leave Philadelphia for my internship and my surgery, and I went to Michigan. Detroit, which was a much more aggressive area medically and much more osteopathic-oriented -- to this day they are. I came back well trained. I had a very busy two years out there, and did an awful lot of clinical work and surgery, and I came back very confident.

CBP: How about before you left? After your four years here.

LF: Well, I probably was an exception because I lived in the College. I lived in the hospital. I was single. I was hungry for all the clinical work I could get, and I literally slept on litters, even when I didn't have to be there. So I had a very good experience clinically, but it was because I was so aggressive in going after it on my own,

independently of what was required. For those that did not do that, there was probably not enough hands-on clinical activity to make them comfortable, as far as the four years were concerned. But there's no question in my mind that it was there if they wanted to exert themselves. And the majority of them did. And if they were a little weak when they graduated, by the time they finished their internship, almost every internship in the profession was a busy, hands-on program. So that by the time they finished that first year of graduate medical education -- their internship -- almost all of them were ready. And, of course, in those days, you didn't need an internship if you didn't want to. So there was a couple of them who went right in the practice.

CBP: Straight out, after they got their degree?

LF: Yes. I haven't a clue as to how they managed. But there weren't many. In fact, I don't think there were any in my class that did that. But many of them -- if not the majority -- went right in the practice after their internship. They went into family practice. There were not many residencies open to us -- at least good ones -- in those days. We were not allowed to go to allopathic institutions

to train. There were possibly some who had a personal friend or family member, that found a way to get into an allopathic program. And usually it was unofficial if they did. There were some allopathic physicians that would take our graduates as preceptors and train them. In those days preceptorships were still being done. The majority of our graduates went into family practice after internship, and then a small percentage -- maybe twenty or twenty-five percent of us -- went into some kind of residency program. My residency program at PCOM was a terrible program as far as -- if you want to compare it to the allopathic programs in urology at the time. But there again, there was very little supervision, but because I was motivated to go after it and to do what I felt I had to do, I made it into a program that for me was worthwhile. But I would go to -- at the time I had a couple of friends who were residents at the VA Hospital at 39th and Woodland. I spent a fair amount of time there. My Chief at the time -- Bob Whinney -- let me do everything and anything. Half the time he never even showed up for surgery, so I did the surgery for him.

CBP: This is the Chief where? Here?

LF: Here. Well, at 48th and Spruce. I was the urology resident. I was Chief Resident from my first day since I was the only one. It's easy to be Chief when there's nobody under you.

CBP: We're going to talk about the urology part of your career in a little while, there are a few things I want to wrap-up -- just backtracking.

LF: Sure.

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

LF: Well, during the days when I was a student, when we had three full years of didactics, and they were divided into trimesters, we literally covered all of the textbooks. Whatever material was in textbooks we had in class. We started at eight in the morning and went through to five o'clock every day. We had anatomy lab, which was our major lab, biochemistry lab, histology lab, and we had a parasitology lab. The professor of parasitology was a D.O. by the name of Phil Lessig. He was an internist. He's long dead. His grandson just graduated from PCOM. The biochemistry lab was an adventure. We had to pass feeding tubes into each other. Long rubber hoses.

We did all the work on our own stomach juices, and then in parasitology, we did our own stool analysis. It was rather iffy at times.

CBP: Do students still do this?

LF: No. Those things are not done today. Students wouldn't know how to begin doing some tests. And there's no need. First of all, even technicians don't do them. Machines do them today. Back then, every test was done manually. There were lab technicians, but they were few and far between. Physicians did most of that work. Course material was just a grind, it was just hour after hour after hour. I probably had every major textbook printed in my own library that I accumulated over the years, many of which I still have.

CBP: How has it changed since the time?

LF: Well, it didn't change very much. Probably through the 1960s it stayed fairly constant, and in the 1970s it was fairly constant. In fact, medical education, until the last three or four years, has remained relatively same, where the basic science courses were given in the first year, and the physiology laboratories that the biochemistry laboratories and the anatomy laboratories seem relatively the same. And I think they're probably

similar now except that the technology has evolved in each of those areas, so has the curriculum, as far as what's being taught. But the methodology has remained the same. The most significant change has started here -- and I think maybe we were ahead of much of medicine in doing it -- was when we started to integrate the basic sciences and the clinical sciences so that it started to eliminate some of the redundancies, and it also started to make the basic sciences more interesting because then they were able to relate to why it was important to know those basic sciences when without the clinical sciences connected, sometimes it just seemed dry, boring and dull. But by tying it in it became much more interesting. And then in the last couple of years or so, getting away from the large classrooms, small group teaching started to evolve, and that's continuing to evolve right now. More and more of the teaching is in the small classes or small groups versus the large amphitheaters from the beginning of the day to the end of the day.

CBP: But what does it take from a faculty staffing viewpoint to do that?

LF: Well, if you're going to go from amphitheater large groups to small groups in smaller rooms, you

obviously need to increase the number of people involved in the teaching process. So there had to be some faculty expansion. In fact, we're struggling with that now, trying to find ways to get our physicians into the classrooms and still have our clinical sites function without interruption. You must continue to provide patient service for the patients that are in those sites. The basic science deans will also have to -- as small groups evolve -- increase the number of basic scientists. But it's the clinical sciences that require more small groups that require more clinical instructors to deal with the small groups. The testing has become more automated. Another innovation that we started early on in the past three years was the standardized patient program. Starting from the first year, we started evaluating our students as to how they relate and communicate with patients. This area of curriculum is now evolving in most of the medical schools.

CBP: What have been some of the significant developments in graduate medical education, particularly in the last five years?

LF: I assume you're talking about here at PCOM?

CBP: Yes.

LF: There are two major considerations. One has been in the size of the programs and the institutions involved, and the other is in the actual individual programs themselves as to how they've expanded. You have to go back historically, as far as the profession is concerned. We were in a preceptorship mode longer than the allopathic side simply because we didn't have the sites to have formal residency programs. And then our programs historically were much smaller, and our programs were also not involved with research. They were basically clinical programs, and were, for the most part, run in community hospitals versus the large tertiary-type centers that the allopathic academic medical centers provided. So it was a different kind of environment and program. The people who finish our programs historically turn into very competent, capable specialists. During much of the training they had to use their own initiative to expand on what was available to them on a regular basis. At the College, each program depended on the individual director and had its own characteristics. Some programs were excellent, some programs were moderately good at best. All of the programs were relatively small, up until probably when the new

hospital on City Avenue was opened in 1970. When I say relatively small, Urology had one resident, and then there was a period of time when we had no residents. In fact, I was the last resident, until I re-started the program in about 1970. That meant that there was no Urology residency here from 1963 until 1970. Surgery had usually three or four residents. OB/GYN had two or three or four residents. ENT had a couple of residents. Orthopedics had one or two residents. Medicine had four residents -- maybe five residents, at times. As far as internship was concerned, I interned in Detroit, and did not personally participate. But at the time, PCOM was considered one of the better internships available to us.

[end of side one, tape one]

PCOM had more residency programs than most, and I think it had a greater depth in clinical faculty than most. That's the reason why there were more residency programs. PCOM probably pioneered for the profession several areas. Urology was one; radiology was another. I believe that the early surgeons here also were pioneers, as far as this

profession was concerned, in the field of surgery. The same with obstetrics and gynecology. The residencies were, I believe, fairly status quo. There weren't significant changes through the 1950s and 1960s, and then going into the '1970s, they started to expand when the new hospital opened up on City Avenue. But then they held the same patterns. There was little or no research done by most of the programs. My program in urology was the first one, and maybe the only one that used the laboratories and did research and published papers during the '70s and '80s. The school always had -- I say always; at least from the time I was a student and some time before, up to the present -- a master's program for residents that would do original research, and I think it's been the only osteopathic college to do that, and that's been a very positive program. My criticism of it is that not enough program directors demanded that the residents do it, so that years have gone by without any master degrees being issued. I received a master's degree in urology upon completion of my residency for original work I did, and a dissertation that I published. Probably three-quarters of my residents over the years have completed their dissertation for

their master's degree in the specialty. But overall, our record has been rather bad as far as research in the specialty areas coming through the residency programs. The number of publications coming out in the institution on the clinical side I've always felt have been less -- much less -- than should be. Your question referred to the changes over the last five years. Actually, the major changes started over six years ago, when I came aboard as President. That was a time of upheaval for the College. There was a financial crisis. Do you want me to get into that?

CBP: No. Just talk about the residencies.

LF: As far as the residencies were concerned, there was an awareness of this crisis by our students and it had an impact on the internship and residency programs. There also was an upheaval of the clinical faculty at that time. So we saw what was a busy and active OB/GYN residency with about six residents -- one of the larger programs at the time -- completely dry-up. When I came on board as President there was not one OB/GYN resident, even though the program was accredited. Surgery was down to just a small number. All of the residency programs had small numbers of residents, if any, in

some programs, such as in OB/GYN. The internship, which had been in the 1920s, was down to probably eight or ten, and the reason for that was two-fold. One, there was a mass migration across the profession to the allopathic programs, which had opened their doors wide and were accepting our graduates in not only internship programs, but in almost all residency programs. The exception was probably the surgical residency programs. They were difficult for D.O.s to get into. So with the upheaval going on at the College, plus the fact that the allopathic programs were opening and perception by our graduates historically up until that time, and to some extent exists to this time, was that their programs were better. We saw a deterioration in numbers -- a considerable deterioration in numbers in the residency programs here. My feeling was that if we were to turn that around, we had to be truly competitive with the allopathic programs, and we had to not only be competitive, but the perception had to change. So we affiliated -- actually, the first affiliation occurred before I came aboard -- that was with St. Agnes. The College had the opportunity to acquire Parkview early on, after I came on board. And when we did that, we

actually doubled our bed capacity and I felt this was the opportunity to move forward into a much larger program, both internship-wise and residency-wise. We then affiliated with Germantown Hospital, which had a long history of being a teaching center. Their history was with Temple. Temple had left them so they were very receptive to having our people come on board. Also with Episcopal, regarding pediatrics and obstetrics. We also lined-up with other hospitals regarding other residency programs. I had instituted in the 1970s, specialty rotations in urology, this probably was the first in the profession to do this with formal affiliations. We affiliated with Memorial Sloan-Kettering for urologic/oncology, and we affiliated early on in the 1970s with Children's Hospital of Philadelphia for pediatric urology. Since a precedent was already set through my efforts with urology, we pursued this course with the other program directors, lining-up very good training sites in almost every specialty. Residencies in OB/GYN, general surgery, orthopedics, etc. were provided training sites. Trauma, oncology, pediatrics, and so forth, depending on individual specialty needs.

CBP: How large is the graduate program now -- your

residency program?

LF: Well, we went in one year -- after we acquired Parkview and affiliated with Germantown -- we went from approximately fourteen or fifteen interns to over eighty. And since that time we've had between sixty-five and seventy interns every year. We had, for example -- in OB/GYN, as I mentioned -- in 1990, we went to zero residents in that specialty, to where today we have -- counting the affiliation we have with Rancocas, which is a community hospital in New Jersey -- approximately twenty-five or twenty-six OB/GYN residents. We went from three or four surgical residents. We now have, I believe, thirteen surgical residents. We had two or three orthopedic residents. We have eight or ten orthopedic residents.

CBP: So these are just now in the different hospitals?

LF: Well, each residency program has its own affiliated hospital, so that it is a well-rounded program providing experience in all areas of their particular specialty. There are no two residencies that have identical sites that I'm aware of, although almost all of them -- if not every one of them -- does have their major rotations within the two campuses -- or with what have traditionally been

the major teaching hospitals for PCOM, which are the City Avenue Hospital and the Parkview Hospital. But that's also changing now because of the new standards of accreditation that the AOA has instituted, which we are very actively involved in.

CBP: If you are providing residents for some of these hospitals -- let's say the one in Rancocas -- what is PCOM's actual role in training that resident versus that hospital's responsibility?

LF: Well, the basic model is that the PCOM Program Director, which is usually the professor of that field, is the overall Director. So if the residency is in Rancocas, the Site Director, which is the physician who runs the program at that site, answers to the PCOM Program Director, that means that the core curriculum that PCOM requires and any other specific curricular needs that PCOM requires are being met at that site, and we have site reviews. We also have times where all the residents come together at a common site for teaching purposes. Although not set-up at this point, the equipment is in place here and developing in other areas where there will be telecommunication and video-conferencing. The residents are paid by PCOM. The diplomas are issued by PCOM and the site is stated

on the diploma. So they truly are PCOM programs. It's like having a satellite campus, really. I think that would probably be the best analogy.

CBP: Okay. I'd like to talk now about specialization and practice. Some of these questions you've already commented on, so if you could just give me a summary answer, so it could lead logically into the next question. What kind of training had you received in surgery -- specifically surgery -- as a medical student?

LF: As a medical student, we had every subspecialty as a course. That's why we had so many examinations. We had urology lectures, we had orthopedic lectures, we had OB/GYN lectures. Formal courses, where we would have ten or fifteen or twenty hours or more of each, and then an examination in that particular surgical specialty. The problem was that we never saw surgery. We read the hell out of it. We were textbook smart, but until we finished that full year, we never -- other than those that, on their own initiative, found a way to worm into an operating room to observe -- we did not see much surgery. Although at 48th Street, interestingly enough, they had an amphitheater. In those days nobody was concerned about fifty students breathing

down over an operating table. Today, obviously, they are behind glass, or they're watching on video, through a camera that's on the surgical light. So we did see some surgery at the amphitheater where we were allowed to come in at times. But most of it was just grinding it out in the lecture rooms.

CBP: So you never were allowed to stand next to the surgeon?

LF: We didn't scrub or walk around. Again, some of us found a way to do it, but there was never an organized surgery, where we were involved, until the end of the third year. Then, of course, when we were in the hospital service, then we had surgical rotations, and when we were on surgical rotations, we were not only responsible for the post-operative care, but we were also the second assistants in the operating room.

CBP: So then you were in the O.R.

LF: We went into the O.R. after the third year, after we were on hospital service, and doing surgery rotation. Then we scrubbed and gowned and held retractors. And if we were lucky enough and had the right resident or whatever, we would be allowed to throw some stitches. And on occasion, we were allowed to do circumcisions on the newborns. I

always wondered why most of the first surgical experience as medical students was circumcising newborn babies when so many things could happen. It seemed to be not the best procedure to let them start to learn on, but historically, that's the way it had been.

CBP: Has that practice changed, I hope?

LF: Well, I'm not sure. I think that they're still probably third- and fourth-year students that, I would hope, not unattended, do a circumcision.

CBP: I'm glad I had a daughter. [laughs]

LF: So by the time we graduated, even though we didn't see a surgery for three years, by the time we graduated, we did know what the operating room was about, and knew how to conduct ourselves.

CBP: What kind of training did you receive after completing four years at PCOM? Internship, residency?

LF: Well, as I mentioned, I went to Zeiger Osteopathic Hospital in Detroit, which was one of our -- I believe, one of our better, if not our best, program at the time, although the College program was pretty good, and Metropolitan had an excellent internship, as far as the profession was concerned. But Zeiger was outstanding, as were a couple of the others in

the Michigan and Ohio area at the time. I had travelled from California and back, looking at our hospitals to decide where I wanted to go. I didn't want to waste it. I wanted to pick the best site that I could. So Zeiger was good. They were very busy, and they allowed their interns to be very active in the management of the patients. And what was more important, and probably why I picked it -- they had residents in the major specialties, which was not the case in many of our osteopathic hospitals that had internships and did not provide a lot of instruction. There was a lot of hands-on practice by the interns, and there was a lot of prayer, I guess, involved, as to whether it turned out right or not. But at Zeiger, we had residents in OB/GYN, surgery, medicine, and a couple of the others. So we were pretty well covered and supervised. Just as my first day in clinical at 20th Street I had my first delivery, I volunteered to cover the outgoing interns at Zeiger when they had their graduation party. So a day or two or three before I was supposed to start my internship, I worked at night. I started at five-thirty in the evening. I was assigned to the obstetrical wing, which was a separate building across the street from

the main hospital. I left that next day about ten o'clock or ten-thirty in the morning, from five-thirty in the evening. I was crawling on my hands and knees. I had delivered ten babies. Ten babies.

CBP: I think you missed your calling.

LF: I had delivered them in the hall, in the labor room, in the delivery room. And not only that, the anesthesiologists were also at the party, so we had minimal anesthesia coverage. I was Director of Anesthesia, as well. Fortunately, I had made the most of my time at 48th Street and 20th Street. So the internship was excellent for me. Because I was so aggressive, I was allowed to do many things, and I developed many skills. I decided in the middle of my internship that I wanted to be a surgeon rather than a medical specialist. I knew I wanted to go into a residency program. I was not attracted to family practice. I wanted to do more than that. By the time I got halfway through, I decided to go into surgery. And then, of course, when I made that decision, then I became much more oriented and made sure I was involved whenever I could into the surgical side of the internship program. And then I stayed there for my general surgery.

CBP: That was one year of general surgical residency?

LF: Yes. One year of general surgery back then. Today it's two years before urology. I wasn't thinking about urology. I was thinking about general surgery. But it became very apparent to me at the time that there wasn't a lot of room for general surgeons in the profession. The hospital sites were limited. We weren't allowed to work in allopathic institutions, and in the osteopathic hospitals -- almost every one of them -- one of the owners usually was a surgeon, and none of them were letting competition in. So unless you knew a surgeon who was in a position of power in the hospital and you were going in as his or her junior associate -- I say 'her' but I don't know whether there were any female surgeons back then -- the chances were you weren't going to be able to make a living. But also, probably more significant than anything else, here I am in the City of Detroit, very familiar with many people, and several of the hospitals, and Detroit was really the hot bed of osteopathic medicine back then, and still is. There was not one D.O. urologist at that time in Detroit, which had the highest concentration of loyal D.O.s anywhere. In fact, the first D.O. urologist came to Detroit the year I finished my surgery. He was a general

surgeon who did a fellowship at the University of Michigan, and then came back to the Detroit area to do urology. But he was the only one, and he didn't start practicing until the time I left. I decided that urology was interesting. The scope of surgery was excellent in that some of the heaviest surgical procedures were done in urology, and that was appealing. I always liked medicine, and urology had more than its share of medicine. I took my residency in urology in Philadelphia. It was difficult to obtain because there were only two osteopathic urology slots in the country. One was at Metropolitan and the other was at 48th Street.

CBP: Two in the country in osteopathic --

LF: Yes. And you couldn't get into an allopathic program. To this day, it's almost impossible for a D.O. to get into an ACGME urology program. So that was the reason for that decision.

CBP: To the best of your knowledge, how did your surgical training in the 1960s differ from that of an allopathic surgeon?

LF: Well, it differed probably in conferencing and research. I got into research but it was all self-motivated. There was no organized or structured program. I did it because I felt that I should. I

needed to more than just learn the technical skills of a surgeon. Technically, there was not a hell of a lot of difference between the two. We were busy in the operating room. We learned surgical technique. We learned how to do pre-op workups and post-operative care, and by the time we finished our programs, almost all of us were technically sound and very capable surgeons. Our didactic background was not nearly as broad, but our practical background -- the material we needed to take care of our patients and to function well -- was sound.

CBP: As a practitioner, how does an osteopathic surgeon differ from an allopathic surgeon, or are they the same?

LF: Well, that's probably one of the more complicated subjects to discuss. Today, the scope of practice is similar. There's a different culture. Starting from day one, there's a different type of student. They're more blue-collar. More of them are coming because they were impressed by their family doctor, who was a D.O., or a relative who was a D.O. Many of them are older, and have a different thought as to what they want to accomplish, as far as dealing with people. I think we're more people-oriented. These are subtle things that don't necessarily show

a difference, but I think you have to know the chemistry because it's a vital part of it. To this day, every osteopathic physician has undergone a rotating internship, whereas for the last -- I forget how long now, but it's probably almost twenty years -- the allopathic profession did away with the rotating internship. Their students had to choose a specialty upon completing their fourth year. They're focused in one area from day one. Whereas the D.O. philosophy is head-to-toe involvement. One of the basic philosophical tenets is that the body is a unit. You can't have something wrong with one part without it affecting the other parts. As a surgeon -- as a urologic surgeon -- I had a rotating internship. I delivered many babies. In fact, as an intern, I delivered over two hundred. To this day, I could deliver a baby. It's like riding bikes. I dealt with tonsils, I dealt with congestive heart failure, I dealt with skin conditions. I dealt with almost every area of medicine during my training years, and early on in my practice. When you combine that with my ability to do manipulative medicine, which I have maintained to this day, I have a dimension that an allopathic urologic surgeon does not have.

CBP: When did urology become a sub-specialty?

LF: Well, urology has been in the profession almost since surgery came into this profession. You probably have a better handle on the accuracy of that history than I do right now.

CBP: I mean treated as such, where somebody would choose to focus on urological disorders and surgery.

LF: Probably it became a specialty when they first developed the instruments that allowed us to look into a bladder.

CBP: When was that?

LF: It was probably the beginning of this century. There was a time I knew the exact history of when the cystoscope was invented, it was probably in the 1890s or early 1900s. When the incandescent endoscopes -- those that you could light-up with little bulbs were developed -- that's when the specialty took off. The specialty progressively developed and matured during the 1920s and 1930s.

CBP: Is that when that incandescent --

LF: Yes. I believe that that was probably somewhere in that timeframe.

CBP: In the 1930s?

LF: Yes. Probably in the 1920s or 1930s was when the more sophisticated instruments started to be

developed. When they developed the first instrument that you could remove a prostate gland through -- that's when urology blossomed into its own. With the new instrumentation you had a need to do many cases in order to develop the skills needed to be good at it. That's when the need to specialize really became apparent. So in the 1930s that was when the specialty really started to come into its own. By the time the 1940s were here, urology was well established.

CBP: What role, if any, did PCOM play in the development of urology as a surgical sub-specialty?

LF: Well, I'm not one hundred percent sure, but I believe that the founder of osteopathic urology was a PCOM professor. That was H. Willard Sterrett, Sr. We had a couple urologists early on. In fact, I think that one of your first interviews was Ed Cressman. I think he was one of the first to be interested in urology. He ultimately decided to be a dermatologist. He probably was our first dermatologist. But Sterrett was the first one, I believe, to establish a formal residency program in urology in the profession.

CBP: When would this be? When you say in the profession, in the osteopathic profession?

LF: Yes.

CBP: When would this have started?

LF: Oh, it would have been in the 1940s. Hartley Steinsnyder was the first resident. There were preceptors before him. There was an M.D. by the name of Green who trained, I believe, Albert Reibstein, D.O. after he did a surgery residency. Albert Reibstein became the Chairman of Urology at Metropolitan Hospital. He just died about a year or two ago. In fact, he did the history for the urologic discipline in the profession -- I don't know whether it was completed or if it's still being finalized. So Sterrett had the first resident. Reibstein had the first resident at Met. And then you had those trained as preceptors. Bob Whinney, D.O., who was my Chief when I was a resident, did not take a formal residency. He got his urology training there and preceptorship. So PCOM had the first AOA accredited urologic residency program in the osteopathic profession.

CBP: Could you outline the history of the Division of Urology at PCOM, beginning with Sterrett, and moving forward?

LF: Well, initially, it was a department. Initially, all of the sub-specialties were departments. Their

original chairs were the pioneers in the hierarchy of the institution, so they were departments.

Nobody bossed them around. It became a division during my time, and it was, I believe, after we had come to City Avenue. I'm almost certain it was in the 1970s that they decided it was redundant to have all these departments, and therefore, Urology became a division of the Department of Surgery.

Orthopedics became a division of the Department of Surgery, and all of the surgical subspecialties became divisions, except OB/GYN, which, to this day, is a separate department.

CBP: How long was Sterrett Department Head?

LF: Well, you had a couple of Sterretts. You had Sterrett Senior, who was the originator. He died before I entered school. When he died, they made Bob Whinney Chair. Sterrett had a son, H. Willard, Jr., that graduated from PCOM. Whinney became Chair about 1953, I guess, when Sterrett died. Sterrett's son, Willy, Jr., was one of my attendings. He was a real character. Whinney was Chair during the time I was a student, and was Chief when I was a resident. And then, I think, Willy, Jr. became Chair when we moved to City Avenue.

CBP: So it was around 1967?

- LF: Somewhere about that time -- yes. Willy Sterrett contracted encephalitis, and became quite ill -- he almost died. When he recovered, he was in practice for a time. He then had to get out of urologic practice because he could no longer capably do surgery. I then became Acting Chair of urology, probably around 1970. I then became Chairman, you can look in my CV to find out the exact dates. I remained Chairman of the Division and Program Director until I stepped down in 1993 when my administrative responsibilities consumed most of my time. Sam Manfrey then became Chair, and Phil Ginsberg became Program Director of the Urologic Residency Program.
- CBP: So it went from Sterrett to Whinney to Sterrett to you to Manfrey?
- LF: Right. But the residency program was Sterrett to Whinney to Sterrett to Finkelstein to Ginsberg.
- CBP: Okay. So the only time the residency program separated from the division head is in the last few years.
- LF: Correct. Three years ago.
- CBP: What would you say have been your greatest achievements as a urologic surgeon?
- LF: Well, I believe that I developed into one of the

best urologic surgeons in the profession. I'm more published than most. I always took a great deal of pride in that. I initiated more research in the field -- in the osteopathic profession -- than probably anyone else. My residency program gave me the greatest satisfaction. I believe it became the best program in the profession -- I say this in all modesty -- to the extent that it's perceived by my associates in the allopathic profession as a comparable program to theirs which, to me, was a monumental achievement. The fact that all of my residents who have finished their programs have succeeded and have represented the College and themselves well, has given me tremendous satisfaction. I have been able to preserve urology as an undergraduate course as a separate entity over the years. PCOM is one of the few medical schools in the country that does this. I believe that it's important and that it serves our students well. I have great satisfaction in that. I've achieved the highest positions in my field in the osteopathic profession. I received the second highest award given by the American College of Osteopathic Surgeons. That was a major event in my life. I've constantly fought to have the educational mission of

the profession upgraded, especially in the surgical fields and especially in urology. I believe that many of the positive things that have happened in that area -- research, publications, scientific presentations -- have been the result of my efforts over thirty years.

CBP: In 1975 you performed the surgical insertion of a urinary bladder pacemaker, the first such operation in the Philadelphia area. Looking back with more than two decades of retrospection, how would you evaluate that achievement?

LF: It was exciting. In fact, I just met with that patient about a month ago. She's now a forty-two or forty-three-year-old lady, and the device is still functioning twenty-two years later. There's a great deal of satisfaction there, but it wasn't a monumental surgical feat. I did not develop the instrument. It was developed by others. It was interesting, it was fun, and for a few patients it worked well. It was just another event in my life. Not a major item. There were other areas of urology that I felt that were even more important than that. I was into laser surgery in urology early on, and we had half a dozen or more major league laboratory hands-on courses that we presented at PCOM to the

profession. Not only for the D.O.s, but also the M.D.s. I was the first D.O. urologist to publish in the Surgical Clinics of North America, I did a chapter on CO2 lasers in Urology. I pioneered and did three or four major studies with the use of lasers back in the early 1980s, before most people knew what surgical lasers were. That gave me tremendous satisfaction. Some of the surgery that's being done now is the result of the work that we did back then. Early on we got into continent urinary diversions and gave laboratory courses with animals to the profession -- to the other residents. That was another significant part of my surgical life. And there are many more. This could go on for three days, you know? [laughs]

CBP: [laughs] Of the surgeons you trained under and worked with, which ones stand out in your mind for their contributions as teachers and/or as practitioners.

LF: Well, they all contributed in many ways. Some of them negatively. Sometimes seeing what you shouldn't do first-hand leaves lasting impressions so you never do it yourself. I won't mention any specific names there. Surgeons that influenced me as far as their skills and their capability in the

face of adversity -- the adversity being the opposition they had from the rest of the medical world were guys like Art Flack, who was one of our early cardio-thoracic surgeons. I remember watching him doing cardiac and thoracic surgery on a young female as a junior student from the amphitheater on 48th Street. James Madison Eaton, who was one of our pioneer orthopedic surgeons, who as a major player in his specialty back in the early 1950s into the early 1960s. Some of the gynecologists that were working -- Lester Eisenberg and Andy DeMasi. Most of them good, solid technicians. The most significant of all of my teachers and trainers was my Chief of Surgery in Michigan, who had nothing to do with this college. His name is Ellis Seifer. And the surgeons that I worked with in my earlier days as a resident. I don't have many good feelings about the urologists as teaching surgeons. I came in as an aggressive surgeon as a resident, and went outside to learn and do the procedures they weren't doing. Basically, I was teaching them, as far as I was concerned. Their contribution to me was to provide the program enabling me to do and develop. But my development, as far as I was concerned, and I think that with a

lot of my contemporaries the same, was mostly due to my own efforts.

CBP: Now we're going to talk about the last twenty-five years. 1974-1999. In December of 1974, Thomas Rowland was inaugurated as PCOM's fourth President. Please comment on his strengths and weaknesses as a leader.

LF: Well, I first met Tom Rowland as a freshman student when he was registrar at 48th and Spruce. My recollection of him then was one who was actively involved with student activities, very interested in the students -- some more than others. He always had his group of jocks. He was always interested in the athletes, that were students, more so, maybe, than the others. But overall, his life was the College from when I first knew him. And, of course, he progressed forward until, as you say, he became the fourth President in 1974. Before he became President, he had a Vice President title, and he was probably the chief Operating Officer under Fred Barth, who was the President that preceded him and was the power in the College for many years. Even after Rowland became President, for a short period of time, Barth still was the power within the College. Rowland's life was the College. He ate,

slept and talked about the College. He probably spent anywhere from sixty to ninety hours a week, every week of the year, at the College. When he first came aboard, he initiated some of the best changes that had occurred in a long time at the College. When he first came aboard, I really thought that we were looking at a change for the better, getting away from the oppressive policies of the Barth years, such as prohibiting our leaving campus for educational activities, and allowing the restrictive policies of professional staff regarding staff privileges in the hospitals and so forth. In the early 1970s it became apparent that we were way behind -- we, the College -- were way behind (in our faculty and in our attending staff at the hospitals) as far as the sub-specialties of medicine were concerned. Up until the 1960s, you had surgery and you had OB/GYN and you had medicine. You didn't have nephrology, you didn't have pulmonology, you didn't have rheumatology. All of those things were lumped into the broad specialties. When we came into the 1970s, we had very few on our faculty in the subspecialties. We had our general internists, general surgeons. We had orthopedic surgeons, ENT's, and urology. But we didn't have the subspecialties

represented. We didn't have nephrology. We didn't have pulmonary medicine. We didn't have infectious diseases. We didn't have rheumatology. We didn't have gastroenterology. And that was hurting us across the board. It was hurting us in the classroom, we didn't have the expertise in these areas in teaching our first- and second-year students. It was hurting us even more so in the hospitals in that we were losing our patient base to the allopathic institutions that had all these subspecialists on their staffs. And one of the reasons that we were so far behind was Barth's policy not allowing our kids to train anywhere else. One of the things that Rowland did early on was to change that policy. He sent out a cadre of our best people into fellowships into those subspecialties. When they finished their fellowships, they came back, and became our attending staff in the hospital, and they became our subspecialty professors, and we took a leap forward and that was so important. For me, who was working so hard to establish credibility -- this equality in the eyes of everybody -- this was a major, major event. Some of the people that came in that period are still here. For example, John Similaro, David Bevin, and

then there's quite a few, of course, that are long gone, but they did make their marks, and they all served us very well. They were bright. They were well thought of. They became established quickly and built their practices, and improved the curriculums immensely. I believe that that was the major accomplishment that occurred during the early years of Rowland's presidency. I believe when that group came back and started a practice and built their practices, they started out with great expectations. They believed they would be able to continue to move forward and upward. But at some point, things sort of slowed down. That group of docs started to look like well, maybe they had gone as far as they were able to go, as far as their salaries were concerned, and as far as their ability to grow professionally. We started to see some of them leave. And gradually, they would be replaced here and there. But things started -- in my view -- to stagnate again.

CBP: Around what time are you talking now?

LF: Well, into the later 1970s and into the 1980s.

Later 1970s, I guess. There's a lot of things that I could get into as to why things happened, but I'm not going to. Rowland's life was this college, and

I believe that he felt that he had to control the entire process. And if he didn't control the entire process, he was vulnerable and since he had nothing else in his life, this was it, he wasn't going to take any chances. I think that mindset slowed the growth and development, as far as the College and its hospitals were concerned. We reached our peak years with him probably by 1980, and then held at a reasonable level over the next few years. Then as far as I was concerned, there began a deterioration of morale and the hospital started to suffer. Of course, a lot of it was not due to anything he did, but due to the fact that the other institutions were opening up all their doors, and competition was becoming fierce. He was a consummate politician, though. He satisfied the needs of many people. He maintained a lot of good contacts for this college and maintained its perception that it was something better than what it had been. And then, of course, he got sick. He was an incessant smoker, and of course, that's what ultimately did him in. He ultimately died of lung cancer. There were a couple of years of slow deterioration, until he finally met his demise. He made major changes initially that gave us a boost -- that were permanent -- and in

that respect, he was a very significant President.

CBP: PCOM has a long history of community service through the clinical practices it has operated in the community. This presence expanded considerably in the 1970s with the opening of a rural health clinic in Laporte, Sullivan County, and health care centers at 20th and Cambria in North Philadelphia, and one in Roxborough/Manayunk, in addition to one at 48th Street. Then, in 1986, the College opened the new Osteopathic Medical Care Facility at Philadelphia International Airport and a new West Philadelphia health care center at 4148 Lancaster Avenue. Why were all these additional centers being opened, and please assess the success or failure of having all these facilities.

LF: Well, the College and the profession, in general -- all of the colleges of osteopathic medicine always accentuated ambulatory care as part of their teaching process. Until the last five or six years, that was looked at as a liability when compared to the high tech allopathic profession with their tertiary center. With all the training in tertiary centers, it was perceived that was the way you made really great doctors. Our people were going out into the communities -- urban and rural -- and

practicing in offices and clinics. Now, during the last five or six years, the realization is that if you're going to be make a real doctor, ambulatory centers is where a significant amount of that training has to be. So our sites have always been important to us. When I was a student, the sites were the two clinics. They were located in each of the hospitals -- 48th & Spruce and 20th & Susquehanna. When 20th & Susquehanna closed, and that was in the early 1970s, we knew that we needed to replace it with a site that would allow our students to continue their ambulatory care training.

CBP: Why did that one close?

LF: Financial. It became a loser, financially, and we had to close it. It was an old obsolete building. I mean, when we did surgery, the windows were opened, and the screens were in, and occasionally we had flies buzzing around, it had wooden floors. It was really an experience. In my lifetime I have seen incredible changes in everything about medicine, from working in a medieval operating room, like at 20th & Susquehanna to what's available today. Anyway, that's why we opened up Cambria. And then, of course, 48th Street closed when we fully opened up the campus here. We needed a site

to replace 48th Street, and that was where Lancaster Avenue came into play. These sites were important to us in order to preserve the ambulatory training facilities that were necessary when the hospital sites closed. The Roxborough site opened because our campus is five minutes from there, and we felt that it would be good for us to have another site close by. Plus, the size of our student body -- was rapidly increasing. My class -- the Class of 1959, I think -- had eighty-seven graduates. When we opened up this campus, we had close to two hundred. We needed training sites for all of these students, and it became apparent that two sites weren't enough. So Roxborough opened. Fred Barth had property in Laporte, and thought it would be a good training site for the College. It turned out to be an excellent move on his part, although I think it was more personal than thinking about the College. It became very apparent that a rural site would be a very important part of our training process. Our students would have rural exposure as part of their experience. Laporte opened up because Fred Barth had an opportunity to buy ground there, and then politically found a way to have the county build a very nice facility. It worked in the College's best

interest and to the students' best interest to have it there. That's how Laporte started. When I came on board in 1990, we had an opportunity to obtain the site that is now at 61st & Chestnut. We now can accommodate our entire student body, and we're constantly looking to improve.

CBP: That's good. It gives me a lot more perspective on why there were so many, and the timing of them.

[end of side two, tape one]

[Second Session - October 3, 1996]

CBP: In November of 1984, J. Peter Tilley, D.O. was elected President of the College, succeeding the late Tom Rowland. Please explain why Tilley was selected and comment on that transition.

LF: The search process began before Tom Rowland died. There was no question that we were going to lose him -- he had terminal cancer. The number of applicants probably was forty or fifty. There were one or two that probably had acceptable credentials. All but Peter Tilley's were mostly from outside, with little or no relationship to the College. Those that did really had no administrative background or

educational background that would suggest that they would really qualify. At least this is as far as my recollection is concerned. Coincidentally, I had recently seen the list of applicants. I couldn't believe that some of them had the audacity to even apply, considering how unqualified they were. Peter came from a family of D.O.s. His father was a former Dean of the Kirksville School, I believe he was quite active in the profession. Peter was well thought of as a teacher. He was in the Department of Radiology. He was bright, he was articulate. I believe that they felt that having been working in the College, and part of the educational process -- that he would probably best meet the requirements of the presidency, and that's why he was selected.

CBP: I have another question for you along that line. How important, in your opinion, do you think it is or isn't for the President to be a D.O.?

LF: I don't think it's necessary. The fact is that Barth was not a D.O. or a physician. Rowland was not a D.O. or a physician. Both of them ran the College reasonably well. Under both of them, major advances occurred that improved the stature of the College. The people who preceded Barth were, I believe, physicians. But they were primarily

associated with the formation of the College -- founding of the College, and so forth. So that is not an essential criteria in my mind. What is essential is that they know the profession, they have experience with the educational process, and they have or can develop a relationship with faculty.

CBP: Please comment on Dr. Tilley's strengths and weaknesses as a leader, including his relationship with the Board of Directors, students, faculty, staff, and alumni.

LF: Well, I had a fairly close relationship with Dr. Tilley. I knew him during the years he was primarily in radiology. In fact, he was responsible for me coming on board as full-time faculty after all the years. Tom Rowland had approached me on numerous occasions, but wasn't willing to present an economic package that was even close to what I was doing in private practice. Tilley had the vision and wisdom to realize that I could come on board with a salary package that would meet my needs and also bring extra revenue into the institution because of the size of my practice. It was under those circumstances that I came on board for the first time. I have been closely affiliated with the

College, as I've stated previously, since 1963, upon completing my residency. Tilley's strengths were just that. He knew physicians, and he could talk to physicians in physicians' language. During the first couple of years -- this worked well for him. He had the confidence and faculty of the staff, and that worked well for him. His weakness was that he had little administrative skill. He had to rely on his staff, which is okay if you have the appropriate staff and they give you the right advice.

Unfortunately, at least in my opinion, the staff that he brought on board, including the CFO and the operators officers and the administrative staff of the hospital, were not the right people. But these were the individuals who were advising Dr. Tilley, and whose advice he took. The net result of that was almost the total financial collapse of the institution, in 1989, and in the first month or two of 1990. Which, of course, were the events that led to my coming on board as President.

CBP: You just answered my next question partially, but I'll put it back to you anyway, in case you want to continue. What were the highlights of the Tilley years at PCOM between 1984 and 1989, and what were the shortfalls?

LF: I don't think there were any significant highlights. There was a period of relative stability and an effort for the College to move forward, which really didn't happen. It remained relatively stable in 1985 and 1986 and 1987. There was significant dissatisfaction of the staff. There were many consultants who came in at great expense. Many recommendations were made to his administration, none of which -- at least of significance -- were carried out. There were several activities that were instituted that ultimately were responsible for the financial troubles that ensued in 1989. The construction and completion of the Muscle-Skeletal Institute at a cost of over two million dollars with no business plan, was an operation never opened for one day's worth of business. At this point in time, it has been renovated into regular office space. That was an example of what was going on during those years. So no highlights. It was a period of stability where there was an awareness of things being attempted, money being spent, but nothing was really happening. Those things that did happen turned out to be negative rather than positive.

CBP: Please describe the challenges Tilley faced in the mid-1980s, particularly within the context of the

changing climate in health care. How were the changes affecting the City Avenue Hospital and how were they affecting the College?

LF: Well, that's a good question because it was always a case of the tail wagging the dog in this institution. The hospitals, as far as my recollection is concerned, never contributed financially to the College. This is diametrically opposite with other academic health centers, where the hospitals actually were the engines that fueled the medical school. For whatever reason, this college has never been able to have a hospital administration with the capability to turn a profit. And as a result, our hospitals had always been a drain -- a financial drain -- on the College. PCOM had two obvious reasons for subsidizing the hospitals, preserving and maintaining them. One being, of course, needing them as training sites for the clinical education of its osteopathic medical students. And the second was, for much of the history, there were no other hospitals for our osteopathic physicians to practice. They weren't allowed until the mid-1960s to get on the staffs of the allopathic hospitals. So for those two reasons, the College had always subsidized, even though for

many years they were losing money -- the hospitals. In the 1970s things were pretty good because the reimbursement policies were so liberal. It was remarkable that we managed not to make significant dollars. It was very difficult not to make money, but we managed to do that. But we didn't lose money during those years. As the Feds and the payers started to tighten-up because of the rising costs of health care, it became more difficult. Our lack of competent hospital administration really started to penalize us. Plus the fact that our physician loyalty -- their use of our hospitals -- never reached its potential. This considering the large practices the osteopathic physicians have had in this area, and the large numbers of osteopathic physicians in this area, most of which were alumni. In 1985, which was Tilley's first year, prospective payments for patient reimbursement started. That was where hospitals started to get paid according to diagnosis rather than for their charges for the cost of care. That meant that there had to be even more efficiency if they were to have a chance of breaking even, let alone make a profit. And true to form, our hospital started to lose money -- more and more money. That became an ever-pressing problem for

Tilley and his administration to control the losses of the hospital. The fact that the College itself, because it had a relatively low overhead, faculty did control costs -- many times at the expense of the students, I guess, that the College itself turned a profit and that profit allowed them to support the hospitals. But after that there was very little, if anything, left to do capital improvements, or to upgrade equipment, to stay on the cutting edge. The rest of the medical world around us was purchasing the latest equipment, expanding services, and starting to advertise, which had never been done before. Competition was becoming more intense, and admitting new patients was becoming increasingly more difficult. And, of course, that process continued through the latter part of the 1980s, which was during Tilley's tenure. Now, you can't blame Tilley for the reimbursement policies that were changing to the detriment of the hospitals, but he did not find a way to turn it around.

CBP: In January of 1986 the Board approved reorganization of OMCP (or PCOM) into five separate corporations: hospital, college, Clinical Associates, diversified services, and management services. What was the

goal of this corporate restructuring and how was it related to the changes affecting hospital finances?

LF: Well, again, I was not privy to the decision-making at that time. It was my impression, based on the presentations and conversations we had, that it was done following recommendations by the law firm that represented us, Blank, Rome. I think the main motivation was to protect the College by forming the separate corporation, particularly the hospital. There were tax laws changed, and I believe that was also the reasoning for the recommendations to form the different corporations, one of which was a for-profit corporation allowing the College to get into some entrepreneurial opportunities should they arise. The Clinical Associates became a separate corporation in an attempt to have them perform as in most academic medical center practice plans. It was hoped that there would be incentive for the doctors to be more productive. That the practice plans would turn a profit or break even, rather than what was going on uniformly -- losing money. The problem with clinical associates was that there was no competent management there either. There was no accountability. And the incentive packages were so weak that those that didn't produce dragged down

those that did, and those that did -- a significant number of them said, "Well, hell, I'm working every day trying to build a practice. Those guys are just milking it dry. Why should I work this hard?" And therefore, even the productive people tended to produce less than they normally would have.

Management never was able to turn that around. That resulted in significant losses by clinical associates. The College continued to be the corporation that saw a positive bottom line, while clinical associates was losing progressively more money. The hospital corporation was also losing progressively more money. The other corporations really were paper corporations, and didn't contribute one way or the other. And then you had the debt service that the College had incurred through its bond offering of about twenty-three million dollars. When all of these problems started to develop, all of a sudden, the College began to violate many of the bond covenants that were held by the bank that held the Letter of Credit for its bond holders. That was the reason for the crisis that developed during the latter part of 1989.

CBP: That leads to the next question. Around 1990, Dr. Tilley began to suggest selling the hospital.

Please describe the different schools of thought about that proposal at the time and the factions that formed.

LF: Actually, Tilley started talking about that in the fall of 1989 -- maybe even the summer of 1989. I can relate to that because that was what triggered my activity. Tilley said to me personally, "We need to sell the hospital, give the hospital away, or close it." Any of those options at that time, in my mind, were totally unacceptable for several reasons. One, I still believed that we needed to own and control our own hospitals for educational purposes. And two, I felt that the potential of this City Avenue Hospital -- we didn't own Parkview at the time -- the potential of this hospital was still great, and if the right things were done, it could succeed. It could at least stop losing so much money. Maybe even break even. Maybe even turn a profit with the right management, which I felt had not been right historically, during the thirty years I had been there. For that reason I went to war with Tilley. And there was a significant -- in fact, a great majority of clinical faculty who felt the same way. Obviously, their livelihood depended on our hospital. The thought of closing it was

intolerable. The thought of giving it away to an entity that could tell them what to do or even shut them out was not acceptable. Or the same thing with selling the hospital, of which there were no significant buyers. We knew he had been talking to Temple. Temple was our competition, for Temple University Medical School to own our hospital, to us was heresy. There was tremendous fractionalization. There were very few, if any of us, that felt that he was making the right decision, and that carrying out any of those options would have been suicidal for us.

CBP: Please describe the events leading up to and including March 9, 1990, at which time Judge Hoffman, Chairman of the Board, and Dr. Tilley, President, resigned and you became Chairman of the Board and President.

LF: Well, as I stated, I went to war with Tilley regarding what he thought we needed to do with the hospitals. I also mentioned that the College was in violation of many of the covenants that related to the bond offering and the debt service. In the latter part of 1989, the Bank of New York, which held the Letter of Credit, became aware of the violations, became aware of the actual financial

condition of the College. Until that time, the College had managed in various ways to hide the fact that it was having problems, but they all surfaced, and the bank intervened. The bank told Tilley and his administration that they better come up with a game plan quickly as to how they were going to stem the losses and to correct the violations, or that they would call in the Letter of Credit. Obviously if they did that, it would have been catastrophic because there would have been no way for the College to pay off twenty-three million dollars of debt without going into Chapter 11. It may have been able to come out of Chapter 11, but credibility and reputation was at huge risk should that happen. The first significant action that Tilley and his administration made to correct the problem was to terminate clinical associates. Clinical associates at that time had about seventy-five -- I forget the exact number -- of clinical faculty on payroll. Basically, their entire clinical faculty was in Clinical Associates. So here you had all of these physicians, who were fully salaried, who were full-time employees of the College, who were given notice that as of -- well, the first notice was that in December they were out of a job, with no game plan

as to what was going to happen to them, no discussion as to how they were going to be kept whole.

CBP: Were they still expected to fulfill a teaching role even though they were out of their guaranteed salaried position?

LF: Well, they were expected to do something, but there was no plan, other than they were going to be fired. At that time Clinical Associates was showing a two-million-dollar-a-year loss on the books. So by doing that, Tilley was able to show the bank, "Here's two million we're saving right here," without any game plan as to how really we would proceed without them on payroll. I looked at that personally, as I was one of them -- as something economically, for me, as not really detrimental. In fact, because of what had been going on over the past year, I was already planning to go back into private practice. This was doable for me because it was my practice coming in in 1985, and my contract enabled me to do that. I said, "Well, they did what I was going to do on my own anyway." But very few, if any, of the others were in that position. Most of them came in right from their residency, and their practice was built by then, and if they left

without their practice, they had nothing. I reasoned that this situation presented an opportunity if I wanted to take it. This institution has a corporation. The corporation was formed in the 1940s, or maybe in the late 1930s -- you have that information. The purpose of the corporation was to allow the clinical faculty and the physicians that were connected to the hospital to have something to say about the operation of it versus just the small Board of Trustees having total control. The doctors, through the corporation, at least on paper, had a way of impacting on decision-making. Up until that point in 1989 when Tilley fired them all, the majority of the corporate members were also clinical faculty. Well, clinical faculty who were employees never voted against administration. Administration recommended, and it was done. I guess it's almost the same way as any publicly-held company that when there's a stockholder meeting, everybody votes for what the Board of Directors recommend, and then historically, that's the way it always worked here. Knowing the institution was falling apart, and knowing that if something drastic didn't happen, it was going to be the end of the College that I had worked so hard

for, I had to make a decision. I knew I could succeed very well economically without the College with my practice. There were many hospitals that I was on the staff of, I could preserve my practice, and maybe even grow my practice. Or, should I do something crazy and maybe a ten thousand-to-one shot that it could even work, and try to change the Presidency and the Board of Directors of this institution. I blamed Tilley for what had happened because he had followed advice of his administration who gave him bad advice. He didn't listen to other people whose advice, if he had listened to, he might have had a better result. I blamed the Board of Directors because they rubber-stamped what the President and his staff -- his administrative staff -- recommended. I felt that they, the board, had not carried out their fiduciary responsibilities, just nodding approval as every recommendation was made. The opportunity was, that all of a sudden the majority of the corporation was angry at the administration, and just maybe angry enough to vote out those members of the Board of Directors -- the Board of Trustees -- that they had voted in, which was the majority of the Board. I think nine of the sixteen Board members were elected

by the corporation. The remaining were elected by the Board itself. I read the bylaws very carefully, and the bylaws said a special meeting of the corporation could be held if twenty-five voting members signed a petition for the specific purpose of that meeting. I proceeded to get a petition signed. I spent hours in the doctors' lounge collaring them as they would come in to make their rounds. I was there almost five nights a week until eight or nine o'clock at night, after spending all day doing my clinical work. About the same time, Galen Young had hired a legal firm to represent some of the docs in an attempt to restore their jobs, and their claim was that there was a wrongful termination. Having the same agenda, but for different reasons, Galen allowed me to confer and get what turned out to be free advice of counsel by his law firm to make sure my petition was right and to make sure that what I was doing was legal, according to bylaws of the institution. I then linked up with other people who were able to give me advice and counsel. Nobody actually believed that what I was trying to do was even a remote possibility. They thought I was crazy but knowing that I was serious, and was credible as far as what

I did -- they supported me even though they didn't think it was possible.

CBP: At that point were you doing this with the vision of your filling that spot?

LF: My vision was that I would call a special meeting of the corporation, that I would make a resolution to remove all nine members of the Board that were elected by the corporation, which was possible if you had a majority of the corporation vote for it, and that the corporation then would elect myself and whomever else in, and we would then take control of the institution.

CBP: Put you on the Board, or put you in as President and Chairman of the Board?

LF: Since I was almost the one-man Army, the assumption was that initially, at least, I would lead the pack, and my thoughts initially were I would lead the pack until everything stabilized, and then I'd go back to my urology practice and teaching. The petition ended up with forty-five or forty-eight signatures. I only needed twenty-five. Forty-eight was an absolute majority of the corporation. So I had on the petition enough names to guarantee that I could do what was planned. I called town meetings, which was very interesting because here I was -- I was not

an entity. I was an individual. I wasn't the President, I wasn't a Chairman. I was Chairman of the Division of Urology, but I wasn't Chairman of the staff at that point and time. I had been in the past. I called two or three town meetings that were attended by -- the last one was attended by five hundred people. The last one was attended by Tilley, who spoke. I also started to discuss what was going on with Judge Hoffman, Chairman of the Board. In fact, when I knew I had a majority vote, I requested that he resign and appoint me to the Board. I told him that I felt it was in the best interest of the institution, and had nothing to do with his long service and dedication to the institution, but that I felt that it had to be done. There was obviously tremendous Board resistance. They didn't believe that this type of thing could possibly happen. The Bank of New York wasn't very happy, either. They were having enough problems figuring, "Here's an administration that knows what's going on, and it's coming up with a plan. Who is the screwball that doesn't have any background?" So they were avoiding it. The Bank of New York ignored me at first, and I'll never forget Judge Hoffman's comment was, "Leonard, the Board of

Trustees doesn't run the institution. The administration runs it." I said, "Judge, you're right, except that the Board of Trustees is responsible for the administration's performance, and I don't see where your Board has done that." I then received the support of the Alumni Association stating that they supported what I was doing. The students were very supportive. All of the constituencies of the College were lining up behind me with written and verbal support.

CBP: What was the timeframe of when you started gathering your signatures for your petition and these factions started to fall in with you?

LF: Throughout the fall, going into the latter part of -- November, December 1989 -- January of 1990. The Judge was then told by the bank to appoint a committee to try to reconcile the differences between myself and the administration, which he did. The bank insisted on sitting in on the meeting that that committee had with myself. The chairperson that he appointed was a board member who happened to have been an alumnus of the College, and initiated the meeting by attacking my motivation and everything else.

CBP: Who was that?

LF: Purdy. Ruth Purdy, her name was. And really, I don't remember ever becoming more incensed in my life because the last thing on earth that I was doing this for was to obtain a position of power. I was doing it to save an institution I worked my butt off for. After she was done, I verbally flattened her. The bank then met with me. I think that at that point they started to realize that they were dealing with a horse that could very well accomplish what it had set out to do. After that meeting I conferred with the Chairman of the Board again, and he, I believe, at that point, realized that it would probably be inevitable. And what I told him was that --

CBP: Him being Judge Hoffman?

LF: Yes. What I suggested to the Judge was that he resign, appoint me to the Board, and then have the remaining Board resign, and I would appoint a new Board, and I would honor him for his years of service, and I would certainly not advance any negative campaign regarding any of the Board members who would resign. At that point the decision was made for the board to do what they did, and on March 9th at ten o'clock in the morning, I was appointed to the Board, they resigned, I appointed the new

Board, I was elected Chairman of the Board and Acting President and CEO. It soon became very apparent that this was not something that I could, in two or three or six months, turn around and then walk out like I had originally thought I could do. The members of the Board strongly advised me to become President, not Acting President.

CBP: Was this a completely new Board? Were there any members kept on?

LF: There were members that I felt were politically right for me to keep on. There were members who I felt that I wanted on. I think four members or five members, maybe, were on the Board originally, that were on the Board that did not step down and I did not feel that I wanted to replace. But probably two-thirds or three-quarters of the Board were new members that I brought on.

CBP: How was the decision made which of the old Board Members should resign and which ones would stay for your Board?

LF: Well, there were a group that were very strongly allied with Judge Hoffman who, when he stepped down, just felt that they should step down, and I was in agreement because I felt that we needed to change the chemistry. We saw them as part of the problem

because they were a Board that was not a proactive Board, but a Board that just rubber stamped. We needed to show the world that a new group -- a younger group, a more aggressive group -- was in place.

CBP: When and how did Herb Lotman become Chairman of the Board and how has he influenced the institution?

LF: Well, as I just stated, I entered as Acting President and Chairman. I soon became -- I don't remember. I was probably about four or six months into it -- I became President and Chairman. There started to develop a faction that was very resistant to me having both positions, mostly led by Galen Young, who felt that one person shouldn't have total control. I felt that for a time I needed that total control. There was so much that had to be done. I didn't have time to start playing with a bureaucracy. I had to make decisions. I had to be able to bring people in. I had to be able to do things. So I maintained both positions, I think, for about two years. And during those two years, we achieved stability far and above what we thought we could. I came on board in March of 1990 and at the end of that fiscal year, which was June 30, 1990, we had a six-million-dollar deficit. June 30, 1991,

our first full year where we were administratively in control, we were looking at a four-million-dollar surplus. We had achieved in that one year a ten-million-dollar turnaround. Not only that, but we had acquired Parkview Hospital, much to the amazement of the world.

CBP: That's going to be my next question, but how did you get from a six-million-dollar deficit to a four-million-dollar surplus?

LF: Some of it, I guess, was luck, but much of it was just instituting sound business practices. For example, when I came aboard and we were in such dire straits, I found that our receivables were averaging a hundred and eighty days and we were discounting our bills at thirty days -- this was crazy. We immediately started postponing our payables as long as possible, and we did everything we could do get the receivables current. We also acquired Parkview in July of 1990, which added a million dollars to the revenue side because of changes in reimbursement consolidations, and economies of scale. Plus, by changing administration, the aggressive changes improving the census in the hospital cut the losses significantly in the hospital.

CBP: Was that ten-million-dollar turnaround in the

hospital, or the combined hospital and College budgets?

LF: Combined. We had been receiving support from the state, which actually, if it wasn't for that allocation on a yearly basis from the Commonwealth of Pennsylvania, the school would have, undoubtedly, folded before 1989.

CBP: Where did the money come from to buy Parkview?

LF: Very creative business dealing. We obviously were unable to utilize money within the College budget because that was totally controlled by the bank, and they weren't about to allow us to get into any activities that put them at risk. We were able to do that by using Parkview, which was in bankruptcy at the time as collateral. We bidded an amount of money which was below the appreciated value or the appraised value of the hospital. It was appraised at about twenty-three million dollars. We bid, in bankruptcy court, eight million dollars. People who were advising me at the time felt that we could raise that amount. They also worked with us to get outside banks to come up with money for the acquisition by using the hospital itself as the collateral. Plus the equipment of the hospital -- we were able to sell that to a company that then

lease it back. The money we received for the sale of equipment was added to the loan we received from the bank. Combining those, we raised nine million dollars. Eight million for the purchase, and another million for operation capital to get started. That's basically how it happened. It was done entirely outside of the College budget. The Bank of New York had no problems because it didn't put them at risk in any way. Just by changing the provider number of Parkview to the College provider number, which -- as a teaching institution, received a higher reimbursement -- added almost a million dollars to the bottom line, the next day. And not only that, but my vision to expand the graduate medical education programs to include other hospitals, was accomplished, in one fell swoop. It almost doubled our own bed capacity, gave us the ability to double our house staff in our hospitals, plus the affiliations. So everything was given a shot in the arm by the acquisition of Parkview.

CBP: What has been the subsequent history of PCOM Parkview?

LF: Well, Parkview worked well for the first year-and-a-half, but the changes occurring in reimbursement, the progressive intrusion of managed care companies

into health care, were resulting in a more and more difficult environment for us. We had a great year in 1991. We started to see it turn around in 1992, as the percentage of HMO patients -- managed care patients -- started to increase. We probably had the highest percentage of managed care patients -- capitated patients -- entering our hospitals than any hospital in the city. We were up to forty percent when most of them were twenty percent. For every patient that was admitted, there was one less patient being admitted with a fee for service plan, and we were losing probably twenty or twenty-five percent of revenue, on each individual patient admitted. So we were looking at a future that was not very bright at all, as far as our ability to sustain the hospitals. I had been in discussions off and on with other entities about doing something with the hospitals and it became very apparent to me, based on what I saw happening in managed care, that we needed to do something. So while I went to war with Tilley in 1989 over his thoughts regarding the hospital, I reevaluated our position. The problem I had with Tilley was that he had no plan. He was just going to unload the hospital. I felt that while things were still looking good, there was

a market -- the developing of large systems -- which is still going on -- was beginning. I knew that our hospitals had a definite value for some institution. We believed we should be able to construct a business arrangement that would protect our mission while allowing us to maintain what we needed to function as a quality teaching medical school, while eliminating this financial burden. That's ultimately what happened. We made the decision. We made what turned out to be a wonderful deal for PCOM with Graduate Health Systems. Both hospitals were sold to GHS for a large amount of cash, plus, most importantly, in perpetuity as long as they were hospitals, they would be our hospitals for the clinical training of undergraduate and graduate osteopathic medical students. Also the acquisition agreement guaranteed that our staff, our clinical faculty, our clinical faculty staff positions -- would be protected: that, they couldn't lose their staff positions or their chairs.

CBP: It's about three years now since that sale of Parkview and City Avenue Hospital. Has that remained true to fact that your attendings still have their positions there, and that your students are getting full exposure to what they need at those

hospitals?

LF: Absolutely. In fact, I think it's even been enhanced because many of our students have had access to the Graduate Hospital in Center City, which has a quality teaching specialty staff. The third- and fourth-year students are just as active as they had been in the hospitals before the acquisition. The house staff internships and residencies, have grown over the past three years, but this also through other affiliations that we've developed. It's worked for us in every possible way, including the fact that our College has never been in a better position financially.

CBP: Do you anticipate any further impact on PCOM by the recent acquisition of the Graduate Health Systems by Allegheny University?

LF: At the moment I don't. If anything, I believe it will be a positive development. Allegheny Health Systems is more educationally oriented than Graduate was. I believe they -- based on discussions I've had with their senior management, that they are aware of the asset we are providing in-house staff for the hospitals, both as far as quality of care is concerned and also economically. They benefit economically by the presence of PCOM interns and

residents. And they also realize that the presence of PCOM undergraduate students gives them a fertile ground for recruitment of potential house staff and staff physicians for the future. So I see this as a positive thing, and thus far, there's been nothing to make me feel differently about that.

CBP: Do you have any concerns with the way that they've gobbled up other medical schools in the city, that they might set their sights on adding this one, as well?

LF: Well, fortunately, that's not their call. We are not in any trouble. As I stated, the College is in the best financial position it has been in its history -- in its ninety-seven-plus years. We've seen in the last six years our endowment funds and our foundation grow from less than eighteen million dollars to where, right now, it's close to fifty million dollars. We're totally independent of Allegheny or any other system. It can't buy us or own us unless we ourselves want to be acquired, which is certainly not the case. We believe that it will probably be economically wise for us to expand our degree granting courses and to expand the school itself, maybe even to develop partnerships with other schools that provide health education courses

and degrees, and we will explore all of those options. But I do not see anybody owning PCOM.

CBP: Before we move forward, there's just one question I didn't ask you before in talking about all the transitions when you came in. As President, you dissolved the separate corporations set up by the Tilley Administration in 1986. Why did you dissolve those separate corporations, and what was the impact of that action?

LF: Well, I'll answer the last part first. There was no impact. The hospital corporation served no purpose. We did not own hospitals and we had no intent to own hospitals. Clinical Associates no longer existed. It made no sense to have corporations that did not function. Clinical Associates no longer existed, so there was no need for that corporation. And as far as the other entities, they also were no longer needed. Since we were financially sound, we didn't have to play games with corporations to protect ourselves for tax purposes, or even for debt problems that might arise. They just became baggage we didn't need to deal with. There were no ramifications at all.

CBP: Okay. I'd like you to clarify something. The Clinical Associates that Tilley was threatening to

fire --

LF: He wasn't threatening -- he did.

CBP: Okay. When you came in as President, did these people all come back in with you at that point, into their same positions, and how was their compensation structured at that point?

LF: That's a good question because what we did then has resulted in what we have now. The original decision that Tilley made was to terminate Clinical Associates. I believe it was in December of 1989. The uproar that followed was so intense, and the realization that you really can't take this group of physicians, and without giving them adequate time, just throw them out on the streets. So they extended the termination until March of 1990. So in effect I came aboard about the same time that Clinical Associates officially came to an end. What I did was to (1) allow each one of them to continue their practice even though legally the College owned the practices. It was my feeling that all of those practices were the result of the work of the physicians who ran them. Therefore, give our faculty physicians their practices, no purchase required. Sell to them at fair market value, their equipment. All of the equipment was appraised and

we paid them what it was worth. That gave them some cash flow. We paid them for their teaching and administrative responsibilities. We came up with a formula, that was fair across the board, and the same for everybody. We paid them depending on the number of hours that they had taught -- we paid them if they were a Chair of a department. We paid them if they were a Chair of a division. If they were the Program Director of a residency, we paid them an amount of money depending on the number of residents in their program. We supported their establishing lines of credit, until they established their own cash flow. There was a two- or three-month time period that it would take for their provider numbers to kick in and for them to start getting their reimbursement checks. And it worked. They stayed whole -- all of them. Now, one or two left for various reasons, but for all intensive purposes, we preserved the entire clinical faculty, all of our teachers were in place, and were secure economically.

CBP: How did the salaries compare to what they were getting as whole-time faculty under the previous plan, as Clinical Associates versus what you have to pay them now for really their teaching and

supervisory responsibilities?

LF: Well, the salaries were not comparable. If a physician was making a hundred-thousand-dollar salary when he or she was whole-time, and that physician was a division chair and program director with four residents, he or she might have gotten paid twenty thousand dollars or twenty-five thousand dollars. So there would have been a seventy-five thousand dollar shortfall. But they had their now private practice income, so some of them probably ended up, after the cash flow kicked in -- were making as much, and some were making more.

CBP: Do you have any idea how much this restructuring of the faculty compensation put the college in the black?

LF: Well, it took what was a losing proposition under the previous administration and allowed the College to fund the clinical faculty payroll out of operating revenue without the huge losses that occurred with Clinical Associates. So we weren't losing money. The amount of money we were paying wasn't anywhere near the amount that the group was losing. We changed the system. My original intent was that when things stabilized, we would gradually hire and restore the full-time clinical faculty and

practice plan. But observing what's happened out there, and knowing that what we've been doing has worked, it didn't make sense to get back into the practice business. What we've done is we've gradually added as whole-time clinical faculty, the Chairs. We now have whole-time Chairs in Family Practice, Medicine, General Internal Medicine, Pulmonary Medicine and OB/GYN. They're full-time salaried positions, who also are running clinical practices. We have a whole-time geriatrician, and we have our cadre of family practice physicians on whole-time.

[end of side one, tape two]

CBP: The campus is currently undergoing extensive expansion and enhancement with construction of the new west lobby wing, a landscaped esplanade, parking garage, and student athletic facility. When was the building plan envisioned and by whom, and how is it being funded?

LF: Well, actually, within the first three months of my coming on board in 1990, we had hired consultants to come up with a master facility plan and a long-range strategic plan. That original plan included changes

on campus, and also expansion of the hospital facility because at that time, we had ideas of grandeur, as far as the hospital was concerned.

When we started to run into difficulty again in 1992 and 1993, those plans were shelved, although we had spent three to four million dollars on hospital improvements that were part of the original master facility plan. When we sold the hospitals, and established financial stability. In fact, we saw we had the ability to grow financially. We then restored the original master facility plan, being able to project the ability to pay for the entire campus plan, which was modified, to conform to the ideas that had occurred three years later. For the most part, it's very close to the original plan that we put together in 1990. I mentioned that our foundation had grown from less than eighteen million to almost fifty million dollars.

CBP: What is that growth from?

LF: For the most part it was now the infusion of money from the sale of the hospitals, which was considerable. That was over twenty million dollars. When we sold the hospitals, our credit rating went up to investment grade. We were able to refinance that original loan, which had oppressive covenants,

that didn't allow us to do anything without permission, selling a bond that had the best possible interest for us. I think it's 5.4%. That actually enabled us to earn more money from our foundation than we paid on our bond interest.

CBP: Did this get you out of the Bank of New York?

LF: We refinanced the bond, got out of the Bank of New York, and added another five million dollars, over the cost of refinancing the old bond. That money was utilized to pay part of the master facility plan. The payment -- the bulk of it is coming from operating revenues because we've been doing so well. We anticipate that there will be very little need for to borrow money from the foundation. Operating capital, plus the five million that we borrowed with the bond offering, will take care of the thirty-five to thirty-seven million dollars we'll be spending for the campus changes.

CBP: Has there been any controversy regarding using funds for capital improvement when tuition costs are as high as they are, and the indebtedness that a student comes out of here with is so high?

LF: There will always be people who say that you shouldn't spend any money on things like that. The fact of the matter is that tuition has risen only

slightly here. In fact, for two years there was no increase at all in tuition. Our tuition is right in the middle. Competitively, we're not the cheapest, but we're far from the most expensive in this area, and even nationally. The success of this college long-term depends on the perception of prospective applicants and future students, that it is one of the better schools. And not to have a facility that's first class, and not to have a faculty that's first class, in the long run would impact in a very negative way. For this college to succeed, we must do these things. And as long as we can control tuition to keep it competitive, we're doing the right thing, as far as management of the school is concerned.

CBP: As President, one of the legacies you leave to PCOM clearly will be its history. By the time of the centennial in 1999, the College will have an organized archive, an oral history collection, an exhibit program, and a written 100-year history. Why have you become the "patron saint" of PCOM's history? What do you see as the value of this effort, both internally and externally?

LF: [laughs] That's the first time I've heard that one. Who said that? Carol Benenson? What do I see as my

legacy here? Is that what you're asking?

CBP: In the area of your being a supporter of the College's history program, why are you really breaking ground in doing that, and what do you see as the value of identifying, preserving and sharing this history, both internally and externally?

LF: Well, I see that the history of the College is basically a mirror-image almost of the history of the profession. The College's history parallels that of the profession. The College has pioneered many of the things that have happened for the good, and in some instances, maybe not so good, of the profession. I personally have made -- a mission in my life has been to try to make this profession and this college credible in the eyes of our allopathic counterpart and the public. I have felt that the group of people that founded this profession, the group of people that founded this college, and most or many of them that have followed them have contributed to the survival and growth of what I believe has been a wonderful profession. Not to have a first-class history, an archival collection and so forth -- if it's all possible to have -- would be a shame. Not to be able to show the world what we are, what we've gone through to be where we

are now would be a shame. Hopefully it will give us incentive to keep going further to be looked at by the world as being a premiere school of medicine that provides a wonderful service to the communities that it serves.

CBP: Looking back on the past six years, how would you assess your strengths and weaknesses as a leader?

LF: Well, I guess my strength would be that I am about as focused as anybody can be. I have had a vision and a mission, and I've just stayed with it. And I think that if I had not done anything, I've established myself as credible, and when I say something, that's the way it is. And that whether people like me or don't like me, I hope that I'm looked at as being fair. I have tried to do what was in the best interest of the College, the people that work for the College who are part of the College, and those that have gone through the College. Because what they are and what the College is, is what I am. My weaknesses -- I guess, as my Chairman says, I tend to shoot from the hip. The surgeon in me does not have a lot of patience at times, and sometimes I'm moving before I've thought it out as far as I should. That's a possibility. I think one of my strengths is that I have no problem

talking about my weaknesses, and try to correct them if I'm aware of them.

CBP: What would you highlight as your accomplishments as President?

LF: The fact that the College is better than it ever has been, financially. That the perception of the College by its constituents, particularly the alumni, is better than it has ever been. I believe in the last six years, we've instilled a sense of pride in the institution and in the profession by the people who are connected to it. I think basically that is what gives me the most satisfaction.

CBP: Are there any events of the last twenty-five years that you feel should be highlighted, that we might not have discussed in this interview? Not necessarily your administration, but the overall last twenty-five years, since 1974?

LF: The most important thing, I think, that has happened is that with the development of the City Avenue campus, the College has become much more visible to the five-county area that it serves, as well as nationally as an osteopathic college. The expansion of its GME program, to me, is one of the most exciting things going on. We didn't talk about

that.

CBP: We did a little bit, I think, earlier on.

LF: The fact that we're seeing our graduates in almost every medical institution in this country, including the most prestigious, is a testimonial to how far we've gone. The fact that no matter whom I talk to -- CEOs and Chairmen of Boards of the biggest health centers -- every one of them who has dealt with our people, as most of them have, have had nothing but good things to say about them.

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

LF: I think that we must continue to develop this graduate medical education program, to integrate it with the undergraduate program, so that we have this continuum of education from the first day of medical school to the last day of their residency, and even further than that because of expanding continuing medical education programs. For that to be meaningful, that means that we have to instill into all of our people what makes them different, and that is the philosophy of the profession, the ability to technically use manipulative medicine, and to actually use it and implement it in their

practices, and for us to not make this a paper thing, or something we just talk about, but do not practice. I think this is starting to happen. What I want to see between now and maybe the year 2000, is that what we're talking about becomes a reality, that our internships and our residencies have manipulative medicine woven into them, where appropriate, and that philosophically, we practice what we preach. If we do, we'll remain a separate, viable growing profession. If we do not do this, we will cease to exist, and we'll be part of the medical community without any significant differences.

CBP: One last question. Historically, professional recognition has been an ongoing challenge for osteopaths. In what ways has PCOM strived to overcome prejudices toward osteopathic medicine and to obtain professional recognition for its osteopathic medical students and alumni?

LF: I believe what I just said regarding our expanding programs -- our students and our house staff are now in many institutions. And wherever they are, they're well received. And wherever they are, there is an awareness that not only are these bright, aggressive medical students, but also, they're from

an osteopathic college. For the most part, not only are they equal to the other guys, but also, we find them better because they are more excited, they're more interested, they're hungry. This has, more than anything else, I believe, in the eyes of the people who are in the allopathic profession -- as well as the lay public -- resulted in an awareness that we are indeed at least equal, and possibly even better.

CBP: Is there anything else you would like to add to this interview?

LF: No.

CBP: Okay. Thank you very much. This concludes my interview with Dr. Leonard Finkelstein, October 3, 1996.

End of Interview

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