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## Arnold Gerber Oral History

Philadelphia College of Osteopathic Medicine

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INTERVIEW WITH ARNOLD GERBER, D.O. (CLASS OF 1940)  
by Carol Benenson Perloff for the  
Philadelphia College of Osteopathic Medicine (PCOM)  
November 26, 1996

PERLOFF: Dr. Gerber, please state your full name and date of birth.

GERBER: [REDACTED]

CBP: Where were you raised?

AG: [REDACTED]

CBP: What section of Philadelphia?

AG: [REDACTED]

CBP: [laughs] Where do you currently reside?

AG: [REDACTED]

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

AG: I didn't. At the time that I graduated from high school, I graduated in a mid-year class, which was January of 1935. The proximity of the college to the high school was really one of the motivating factors. I had very little association with the osteopathic profession prior to that time. The family used local physicians in the area of West Philadelphia.

CBP: Did your family use osteopathic physicians or

allopathic physicians?

- AG: I think the last physician we used primarily was homeopathic. It was a Dr. Terry, who was at 47th and Spruce. His office was right there, and it was in rather close proximity. Then there was an M.D. on the same block where I resided as a child, at 4629 Walnut Street. He was like 4633. Very close.
- CBP: Had you had an interest in medicine other than just being located near the colleges?
- AG: No, I wanted to be a chemist, and actually, I applied to Drexel, to go into Chemical Engineering. I had to wait until my records were all obtained and so on. In the meantime, I happened to stop into the college just to see what their curriculum was, and they had chemistry every year, so I was interested.
- CBP: Were any family members or others influential in your upbringing, involved in the medical profession?
- AG: No.
- CBP: What college experience, if any, had you had prior to matriculating to PCOM or PCO as it was called then?
- AG: At the time that I matriculated, the requirement was one year of pre-osteopathic college, and the course was given as a pre-osteopathic course at the College of Osteopathy, so that I spent five years as a student. One not as an osteopathic student, but as

a pre-osteopathic student, and the procedure was to take the course there, which was an excellent course. There was only about twenty-five or thirty of us in the class. We then took a state examination, which would qualify us for one year of college credits, primarily in chemistry, physics and biology.

CBP: Were those the three courses that you took in the pre-osteopathic program?

AG: Yes. And then you had minors. There was a mathematics course that was taught, and there was an English course that was taught. And these courses were very all-inclusive. Biology included everything from embryology, paleontology, catanatomy, histology, botany. The English course went into the didactics of writing -- trying to teach us professional writing, vocabulary -- medical vocabulary, and then there were one or two classics that we studied. Chaucer was one that I remember, and there was one other that I don't recall. Mathematics was primarily trigonometry. The physics course and chemistry courses and the biology courses took up most of the working hours. We had two laboratories every day, of two hours each, and a course in each of the sciences every day -- a lecture class. We went from eight in the morning

until four or five in the afternoon, and a half day on Saturday.

CBP: Was this a twelve month course?

AG: Well, it was two semesters. In other words, you started in the fall and ended in the spring. A typical college year.

CBP: And then the following fall you matriculated as a freshman?

AG: Yes. That's right.

CBP: Had you gone to West Philadelphia High School?

AG: Yes, and I went to the grammar school at 47th and Locust. That's why I say my entire education was in one city block.

CBP: Well, then, I'm not even going to ask you why you selected PCOM for your education because you have made that very clear. [laughs]

AG: Yes, there's no reason.

CBP: What were the highlights of your educational experience at PCOM in the late 1930s? Not the pre-osteopathic course, but the actual four-year degree program?

AG: I was very pleased with it. I graduated with a very satisfactory attitude toward the college and the hospital. I felt that I wanted to continue in a career in the osteopathic profession. I was very stimulated by the course and I actually was next to

the youngest in the class. Most of my classmates were either pharmacists or college graduates, and I was fortunate when I graduated. I had the highest average. I was first in the class.

CBP: Could you talk to me about any particular courses that stick out in your mind, or professors, from your experience as a medical student?

AG: Yes. Pathology. Dr. Otterbein Dressler, who was Professor of Pathology and pathologist to the hospital. He was a very exciting type of lecturer. His courses were the first that I was ever exposed to where there was a visual audio type of presentation. Every class was a slide presentation.

CBP: And that was a new innovation in education?

AG: To me.

CBP: To you?

AG: Remember, I had no college experience. It's possible that it wasn't that innovative to the other members. The pre-40 class that eventually went in to the freshmen class for 1940, I guess, were about twenty-four. No more than that. And the class itself -- the osteopathic class -- was about seventy or eighty.

CBP: What else do you remember about Otterbein Dressler?

AG: He was a bibliophile. He was the type of man who was always reading -- always had books. I

remembered him as a child. He would be passing my home, going to and from his apartment. He lived in the neighborhood -- I think on Chestnut Street. He remembered me and I remembered him. [laughs] You know, I didn't know who he was at the time -- just this one man every day would be walking past. He really, I guess, had an initial impact on almost all the students. He was an excellent teacher. A very well prepared type of lecturer. He never used notes. He had total recall. I really mimicked him as I progressed in my career. He and the orthopedist that I studied under.

CBP: Would he have been an approachable person?

AG: Oh, yes. Yes. Very warm. Friendly. Very gracious. Welcomed anyone into the office, which was -- at that time -- I don't know if you're familiar with the building at 48th and Spruce Street.

CBP: Just from what I've read about it and seen the diagrams.

AG: You haven't seen it?

CBP: I've seen it from the outside.

AG: Well, at the time it was built, I was a child. I remember it being built there. I think it won an architectural prize. But actually, the building itself was rather unique in that one wing was the

College and the other wing was the Hospital, and in the building was the administrative offices on the first floor. The second floor in the middle were classrooms that were later taken over as hospital rooms. The third floor was the operating suite in the middle. The remainder of the building was under gables. Very sloping roof -- shingled, gabled roof -- and that was the pathology lab, and he had a tiny little office up there, right outside the autopsy room, joined it, really. This was his office. I think it was smaller than this. That was the slab for autopsies -- right outside the door. They only had, I think, two refrigerators. And then adjacent to it was the laboratory of the hospital. This was all in the center portion that separated the two wings. If you ever came up there, he always had time to speak. He loved to meet people. He had a very gregarious type of manner. Always pleasant. I never saw him show anger, except later in the political field, where the hospital was going through a very difficult time. But he never showed anger with any of the students or the trainees who were under him -- fellows, and the interns coming up.

CBP: As a medical student, did you assist Dr. Dressler with the hospital autopsies?



AG: As a student, I did not. But we observed it. We'd be called in if they had an autopsy.

CBP: Were there any other professors who stand out in your mind?

AG: Dr. Cressman was a very articulate type of lecturer. Actually, I think he had voice training. He spoke again in a very presentable fashion. Very coherent, well organized lectures. He was in dermatology and histology. Eaton was a good lecturer. He was more dynamic, more jovial type. Almost like a Falstaffian character. He always had a gesture. He was a well organized lecturer until he became extremely busy, and that was already after I was finished and taking over the lectures.

CBP: Please describe the surgical training you received while a medical student under the tutelage of Drs. James Madison Eaton and Harmon Y. Kiser.

AG: Well, Kiser we will just skip over. He was not a good lecturer, and he was not the highest ranking surgeon in the field. Eaton I was only exposed to as a very dynamic character who you saw at every conceivable hour of the day or night. He was very active. And as I knew him, he was a general surgeon -- at that time as a student. The exposure as a student was primarily in the operating room in the

third and fourth year. He was like the fourth person at the pathology and the operation, rather than being a true assistant. You scrubbed and you were holding a retractor and nothing more.

CBP: When did you begin to observe surgery in the surgical amphitheater on Saturday mornings?

AG: Oh, I think when I was a freshman we'd go in there and watch.

CBP: Was that a required --?

AG: No, no. The requirement wasn't until the junior year, I think.

CBP: To go to the amphitheater?

AG: Yes.

CBP: Did you get any hands-on experience in surgery, other than holding a retractor now and then?

AG: Sometimes in the emergency room, but very little because the interns were trying to grasp it. There was that scope of work that was rather minimal that was coming in. Don't forget, it was, I think, no more than an eighty- or ninety-bed hospital. The emergency room was fairly active, and Eaton happened to be in charge of the emergency room.

CBP: Would you do some suturing in the emergency room?

AG: Occasionally, if you had a rather well-intentioned intern or resident who was in there. They didn't

call them residents. You got your internship for one year, if you were fortunate enough to get one. And then you were appointed a second year, and as second year, you would be going into a specialty training, like as a surgical trainee, and third year -- some stayed as long as a fourth year there.

CBP: One of the things we're going to talk about in this interview is the development of the residency program and the distinction between that and the fellowship program that preceded it. Given the perspective you have from your years as a teacher, please describe how the curriculum has evolved since the 1930s. For example, major trends or new courses in the medical student education.

AG: Well, I think it progressed slowly, but in line with the overall field of medicine. The innovations that were brought in and the changes in treatment were incorporated in the progressive development of the school as it got larger and more encompassing. This was not only in the undergraduate, but in the graduate education.

CBP: Could you give me some specifics, please?

AG: They never had a true residency there when I was a student, and even when I first trained in orthopedics. The residency program, I think, didn't

start until possibly 1949, from 1950, and then this was starting in all the specialties. Prior to that time, they never had a medical resident. They never had a true surgical resident as such, but he was a fourth year -- we would call him the resident, but they didn't have a real residency program.

Actually, it was the senior in-house physician, and as you went up the ladder, if you went past the internship, you got more and more responsibility and became in charge of a group of interns, and then you were in charge of all the interns, all the house staff. And if you stayed longer than a third year, why, it was just administrative. The responsibility was re-delegated to juniors coming up after you.

CBP: As a teacher, what would you highlight as the significant developments in the methods and techniques used in educating medical students?

AG: Well, I think the variation was the heavy concentration on didactic education. In other words, the lecturers. The exposure to displays. Visual, as I described. Anything else in the practical sense was very minimal. We would go out seeking it on our own. We would sneak into the autopsy room at the Philadelphia General Hospital. One of the pathologists there was very amenable to

osteopathic students. Others, if they found out you were an osteopathic student, asked that you leave.

CBP: Who was that that was amenable to the osteopathic students?

AG: A man named Robinson. His nephew was in the class ahead of me. Marvin Blumberg. He was a very eccentric character. I don't think he ever married. He lived in a little boarding house at 52nd and Sansom.

CBP: Is this Robinson or Blumberg that you're speaking of?

AG: Robinson. [laughs] Blumberg was a very conventional individual. Married and had children, and so on. He's retired in Florida now. I knew him as a student at West Philadelphia High School. He was a year ahead of me. There were a few others who were in the Osteopathic College at that time, that I knew from West Philadelphia High School. One who came in later, Walter Willis, and became a dermatologist, was in my high school class, and he enrolled, I think, by the time I was a senior in PCO. I was getting out when he was coming in. What was the exact wording of your question?

CBP: My question was, "What were the significant developments in the methods and techniques used?"

We started off talking about the emphasis on didactics and the visual.

AG: The fact that we actually went out seeking it. Some of the graduates would invite you to their office to observe their office practice. Some of us would make an individual contact to take advantage of the friendship of someone. We would be asked to make rounds. For instance, I think when I was a freshman, I had a cousin who practiced in Youngstown -- an M.D. -- who had a residency. He gave up his practice to take a residency in thoracic surgery on Staten Island. At that time, Staten Island had the biggest tuberculosis institute in the country. Seaview Hospital had a bed capacity of, like, six thousand, just for tuberculosis. Their training was very crude and consisted primarily of horrible procedures, almost monstrosities, as far as their effectiveness. Thoracoplasties, where they crush the whole chest, to try to rest the lung on the side. I'm just citing this as an example, that anything we could grasp to give us more exposure to the healing arts in whatever field, we would take advantage as individuals, or maybe little groups of two or three. You'd form cliques in the school as you went through the classes, went through the

grades. And because of this, one in the clique would say, "Gee, Saturday morning I can get into such-and-such hospital," and then two or three would go with him. That sort of thing. We had a very clear delineation of our position in the healing arts heritage -- we were the lowest of the totem pole. Most of the M.D.s in the city had no recognition for a D.O. We weren't accepted in the hospitals whatsoever, and we had very little hospital experience. If you didn't get into an osteopathic hospital -- only about I would say ten or twelve people in my graduating class got internships -- the rest went right into practice, right from the Osteopathic College.

CBP: When did you see this bias against osteopathic physicians changing?

AG: Oh, I would say the real change came with the Vietnam War. With the Second World War, some of my classmates were taken in as enlisted men, and the best they did was many became officers through the medical administrative corps. The others may have been sergeants and corps men -- things like that. There are still men around that I know who served as enlisted men. They were already graduate D.O.s. There was a slight increase in harmony. A little

more acceptance prior to Vietnam. But Vietnam was when they actually solicited D.O.s to come in as medical officers. Before that, there wasn't any way to go in, unless you got an M.D. degree, and that was part of my background. My major exposure to surgery was not as a D.O. When I was in my second year of fellowship in orthopedics, I left Philadelphia to go to Kansas City to a really unrecognized school that gave a medical degree and gave credit for three years of osteopathic education. And you came out with an M.D. Well, we all who went there, who selected that course, went there with the concept that we could get into the medical corps with that M.D. You could. It was recognized in one state only -- Massachusetts.

CBP: Could you please work out this chronology for me. You went out to Kansas City for an M.D. after you got your D.O.?

AG: Oh, yes.

CBP: What years were you in Kansas City?

AG: When was Pearl Harbor?

CBP: The end of 1941.

AG: I would say in the Fall of 1941. No, December of 1941 was Pearl Harbor?

CBP: Yes.



- AG: It was then in the Fall of 1942.
- CBP: And up until then you were doing an internship?
- AG: I did my internship at PCO. I was fortunate to get an internship there.
- CBP: So after your internship at PCO --
- AG: I then got a fellowship in orthopedic surgery.
- CBP: Where was that?
- AG: At PCO, under Dr. Eaton. I guess I was fourteen months into that -- that would be the correct chronology -- fourteen months into that, when I left to go to Kansas City for nine months to get the credentials to get the M.D., and then I got into a New York hospital for two years as a surgical resident.
- CBP: Am I correct in saying that you went to get that M.D. just to get yourself an orthopedic residency in an allopathic hospital?
- AG: No. To get into an allopathic hospital with the thought that I'd be called into the Navy or Army as a medical officer.
- CBP: So did you then get your M.D. degree with the intention of using it to get into the Armed Services?
- AG: Yes.
- CBP: Were you being drafted for an --?

AG: No, I was on a two-way deferment. I think that was -- I don't know whether that was marriage or not. I think it was a professional deferment at the time. A lot of this was left up to the local draft board. They would evaluate them. My local draft board included the College and Hospital. So they were attuned to the fact that there was a physical plant in osteopathy. Many of them may have not have known what an osteopath was, but they knew it was a medical facility. I was married a few days after I finished my internship, so I was married about two years -- it was in our second year of marriage. I was married in 1941. That would be right. That would be the end of my internship.

CBP: What was the college in Kansas City that you went to to get your M.D. degree in 1941?

AG: Kansas City University of Physicians & Surgeons. It's non-existent now, and it only had recognition in the State of Massachusetts, and I took the licensure in Massachusetts as an M.D. That was to give me my credentialing to the credibility that I had the education and had the degree.

CBP: For the Armed Services?

AG: Yes.

CBP: Did you in fact end up in the Armed Services after

that?

AG: No. Do you want me to continue along the line?

CBP: Yes, sure.

AG: I got into St. Francis Hospital, and there it was also just by good fortune of mishandling in their administrative department. I could not fill in a pre-professional school education background. So that I skipped it in the application, and it was overlooked at the hospital -- St. Francis in New York, which is non-existent now. I got no response from the hospital, and I guess it was the first week in June -- the course was over. We were coming back to Philadelphia, and I got a telegram. "Do you or do you not accept the position at the hospital?" They were under the impression they had even sent me an approval that I was accepted, and I, of course, wired back immediately. "I will be there July 1st."

[laughs]

CBP: So you applied to St. Francis?

AG: One of many.

CBP: For residency?

AG: Yes.

CBP: So you did not then end up seeking military service?

AG: No. Then I was called in for a naval examination and rejected on myopia -- on my eyes.

CBP: So then you ended up at St. Francis for two years?

AG: Well, I was already in my second year at St. Francis.

CBP: By the time you were called up to be examined for the military?

AG: Yes. But I was never called up for the Army. They were all very separate and distinct. The Army, Navy. The Air Force was under the Army. I was never called up by the Air Force or the Army. Just the Navy, and that was a two or three-hour examination. I was rejected -- just out of hand. They sent me over to the Brooklyn Navy Yard for consultation about the eyes and just said, "You're not accepted." But it was based on that. They had no concept of my professional background at that level.

CBP: Getting back to this discussion about the changes in the perceptions or acceptance of osteopaths.

AG: Well, in the Korean War, we were still being called up, but in the Korean War, they were calling up the men with the medical degrees from unapproved schools. I was examined at that time by the Army, and I was rejected on medical reasons.

CBP: At that point, though, they would allow an osteopathic physician to practice in the military?

- AG: No, they were being accepted on the basis of a secondary medical degree. Similar to the situation that I've described to you. They were more attuned to the fact that there was a greater field of people they could get. Physicians were at a premium. The men that went through the Second World War they couldn't call up again, unless they maintained a reserve commission.
- CBP: But does that mean that the government was open to letting osteopathic physicians practice in Korea?
- AG: No, they were not taking D.O.s into the medical corps of the Army and Navy. There was an Air Force then. Or the Air Force. Or the public health service.
- CBP: So when they were calling up D.O.s, then, it was to serve as --
- AG: Anything.
- CBP: But not as medical physicians?
- AG: Yes, but they weren't calling them up. The Korean War didn't have the demand for the vast manpower. They weren't drafting them right and left as they were in the Second World War.
- CBP: With Vietnam, as a policy, the government was willing to call up D.O.s to serve as medical practitioners.

AG: Yes. They came in as, I think, with a first lieutenancy. Many of them stayed in, as you know, and made an excellent career in the military. But that was the first time that they really called them in. Now, before Vietnam, I think the Public Health Service was utilizing D.O.s. That would have been before the 1960s. I guess the end of 1950, the public health service, at the time of war, was converted into a military portion of the Coast Guard. In other words, they always served as the Coast Guard, but in a semi-military form. For instance, they have a variety of ranks. If they're in public health service they get physicians, surgeons, assistant surgeons, assistant surgeon general. They keep going up, but each one of their ranks has an equivalent of a military title. For instance, a boy who I know very well has stayed in as an M.D. He went in after he finished his residency in OB/GYN, and has always stayed in the Public Health Service, so that he now holds a rank that's the equivalent to a colonel, and he's staying until he retires. He's made a career of this. Most of his work has been in all civilian capacity in the Indian reservations both in Alaska and down here, and he's still on an Indian reservation in New

Mexico at this time. But the Public Health Service, I think, opened up, and I think it was Murray Goldstein who was one of the first who went in. That was in the Public Health Service. That, as I say, was a quasi-military. In time of war it becomes military. They have their own uniform and everything else.

CBP: If Vietnam made it government policy to accept D.O.s or to recognize D.O.s, my question for you is how did allopathic physicians accept you at that point, and how did the public accept you at that point? Even if it was a government policy, when did it be accepted and actually filter down into your medical colleagues and the patient community?

AG: I think the latter part of the 1960s and wholeheartedly from 1970, on. You just saw this continuous -- I guess almost open invitation to come join us. And, of course, California did. They would have done it in every state. I think they would have been very glad to get the entire osteopathic group to give up the D.O. degree and accept an M.D., and, of course, the M.D. I had, I've never used in any other capacity except really using it for my own purposes for the residency in New York. And they had no idea I was a D.O.

CBP: In New York?

AG: Yes.

CBP: I'd like to talk a little bit more about your experiences as a medical student at PCO, back in the mid- to late-1930s. As a native of West Philadelphia, how would you describe the neighborhood around 48th and Spruce Streets, as far back as 1929, when the College began its move out there?

AG: Oh, it was quite an upper white collar class. It was very affluent. Apartments in Garden Court Plaza were one of two of the finest apartment houses in the city. Almost all the homes -- there were these massive three-story homes on Larchwood Avenue and Cedar Avenue, Osage Avenue. Walnut Street was very well developed. And as I say, it was a predominantly white collar neighborhood.

CBP: How and when did the neighborhood noticeably change?

AG: I started practice when I returned from New York in 1945, and resumed my work with Dr. Eaton and my affiliation with the College and the Hospital. My office was at 5040 Chestnut, and that was still white, and I moved to Bala Cynwyd -- my present home -- in 1952, and it was then changing. These were all junior vice presidents of banks, and things like



that, who lived on the street there, or they were stockbrokers -- that sort of people. The people who retired to the Union League when they got too old or they lost their wives. I guess when I moved out, there was already a rapid transition as the entire area of West Philadelphia was just changing over.

CBP: So now you're talking early 1950s, when you're seeing this change?

AG: Yes. I kept my office there at 5040 Chestnut Street until about 1958 or 1959. Then I moved in town and sold the building there.

CBP: What were the highlights of your social experience at PCOM in the late 1930s?

AG: It was a most enjoyable five years. I loved the College and I was always there. I took part in social activities.

CBP: What were some of the social activities you participated in?

AG: Well, there was a fraternity which was actually a fraternity at that time, rather than a professional club, as the LOGS are now. I never took any active part in the national organization. I was President of the chapter in my senior year. I met my wife, actually, at one of the dances that the fraternity gave.

CBP: Where was Lambda Omicron Gamma located?

AG: They never even had a house until after I graduated.

CBP: Then where did they meet?

AG: They would meet at many of these restaurants.

They'd take over a room for the night -- that sort of thing. It was well organized. They had meetings. I guess -- I don't think it was the most influential, but I think it was the largest of the fraternities because almost any Jewish lad who came in, joined the LOGS. Primarily for getting added exposure to medicine, because the older men who were in practice welcomed them into the offices. For instance, Abe Levin -- his son-in-law is on the Board now -- President. He would welcome all the kids into the office in the night hours. Physicians had night hours in the neighborhood every night of the week, and you could always go down there and watch. He'd let you do anything.

CBP: What became of LOG here, at PCOM?

AG: I don't know.

CBP: Is it still in existence?

AG: I think it is, but it's an all-inclusive organization that brought in women. It became non-denominational, so that it's really -- at the present time -- a very open, professional

organization of osteopathic students.

CBP: What was the role of the Interfraternity Council in which you served when you were a medical student?

AG: It wasn't too strong because at the time there were three really predominant organizations. There was the Atlas Club, the Iota Tau Sigma and Phi Sigma Gamma. And they all had houses, and they were the typical fraternity houses, and actually, they were only seven blocks away from the Penn fraternity houses on Spruce Street. I had no more than the contact in my later years at the school, when I was the Chapter President of the LOGs, just to sit-in on the Interfraternity Council, but not much else. It's not a vivid memory.

CBP: You matriculated at PCO during a decade of transition for athletics at the College. In the early 1930s, PCO had several active varsity teams such as basketball, baseball, swimming, track, bowling and tennis.

AG: Well, track was really the outstanding thing that they did.

CBP: Why was track the outstanding sport?

AG: They had an olympian who was a student.

CBP: Who was that?

AG: I don't remember right now.

CBP: Was it Harold Osborne?

AG: Yes. Harold Osborne. As a matter of fact, he was our teacher in mathematics. When he was in Illinois, he took an educational course, and I think it was a 1924 Olympics. Either 1924 or 1928 Olympics. I guess it was the 1924 Olympics that he was the world decathlon champion. But his forte was really jumping the high jump and the broad jump. There was a young fellow from Philadelphia -- Furey. I think it was Joe Furey or Bob Furey. His family was osteopathic.

CBP: There was also a William Furey.

AG: Maybe it was Bill Furey. He was a big fellow -- larger than me in size and weight. Osborne was a very mild, statured individual. I don't think he weighed more than a hundred and eighty-five pounds. The two of them would be entered in all these Class B divisional schools, like Swarthmore, Haverford, Drexel, and they would take the meet between the two of them. They would take all the field events, and then place second or third in the running events, and the two of them alone would win the meet.

CBP: What was Osborne like as a person?

AG: Very nice. He was very sedate and not cold. Almost shy, as I remember him. When I was a freshman, I

thought I'd go out for the team -- the shotput, and then I tried track for distance, because they wanted distance runners, and I was never any good at it. I never competed with them. But that was the one field where they were outstanding.

CBP: By 1940, the only sports at PCO were intramural. Do you have any insights as to why, in the beginning of the 1930s there were all these active varsity teams, and by the end of the 1930s, it was intramural sports and maybe a track team?

AG: They had a very dynamic individual named D'Eliscu, who was a combination of a P.R. man, athletic director, and it was his concept of bringing these high school kids in who were local champions, so that he brought in swimmers that were still men at the school -- nine enrolled as freshmen who were on the swimming team, which died out. One was Rugerio Flocco, who committed suicide, unfortunately, after he graduated. Another was Sy Lubin, who I think is retired. I don't know if he's here or down in Florida. But they were brought in as swimmers. Oh, and Bud Highlander was brought in as a swimmer. He was a radiologist, also retired now, if he's still alive. Baseball -- I don't know. They had no teams when I was associated with the College, or after.

Basketball became very prominent after I left. I guess it must have been in the classes in the 1950s that developed basketball.

CBP: Yes. Tom Rowland helped rejuvenate that.

AG: Yes. He was influential.

CBP: They had varsity basketball back into the first decade.

AG: Well, in the 1920s, they had the basketball and baseball, but then when I was at the school, swimming had died out already, the year I came in. They had the track, which was full-blown a year or two before I entered, and then continued for another year or two, and then that died out.

CBP: Why do you think these athletics were dying out at PCO?

AG: Well, they didn't have the men going out for the team. [laughs] These were flukey individuals. These were trained athletes that were brought in, or in the process of training. They had already made some name for themselves. Flocco won an Atlantic Junior Diving Championship. Bud Highlander was a speed swimmer and Sy Lubin was a speed swimmer.

CBP: So is it that the recruitment of athletes had tapered off?

AG: Yes. They were recruited by D'Eliscu. He

originally -- this is almost like mythology. I have no foundation for it, but the word was his name was Frank Delinski, and he was an athletic trainer, and he took the Olympic team to -- I think the Olympic track team -- to Japan, where he got an honorary M.D., which did not mean Doctor of Medicine. It meant Doctor of Man. He used the M.D. after his name. And then his name, supposedly, was changed to D'Eliscu. As I say, I have no foundation of fact. [laughs] This was just the rumor in the school at the time. That was his expertise -- his P.R. -- his ability to get the school in the public eye. The best way to do it was to get into athletics. And he did well with these little teams. He certainly knew how to handle it. I know that he ran the Charity Balls, and when I was a freshmen and went to the Charity Ball, it was the biggest event in my life. I had never been to one of these things.

CBP: That's a question I have for you. One last question on athletics. When these athletes were being recruited -- swimmers, track -- were they given athletic scholarships?

AG: I don't know. I have no idea whether they were given scholarships or were just admitted to the school with assistance, that they could be slow in

paying. I really have no concept as to what their make-up was referable to a relationship financially with the school.

CBP: The first Charity Ball was held in 1935. What do you remember of the Charity Ball?

AG: Was that with Paul Whiteman?

CBP: I believe so.

AG: Well, everybody was in formal dress, and I mean tails. Was I twenty-one then? I know I got a full dress outfit when I was twenty-one -- a gift. Top hat and all. And that's the way they dressed. The tuxedo was the exception. Everybody was in tails and white tie. I was extremely impressed because I had never had any concept that a relatively small institution like this put on this very grandiose gala event. It was at the Penn AC, which was on the East Side of Rittenhouse Square. It's now a condominium.

CBP: The Penn Athletic Club?

AG: Yes. It was one of the few buildings in the city that could hold anything over five hundred people -- a ballroom. The Bellevue was smaller -- a little smaller -- and the Broadwood could do it. That's now been demolished. That's where Hahnemann expanded. But the Penn AC -- the affair -- I was



overwhelmed with it.

CBP: Did the students typically go to the Charity Ball?

AG: Well, not many freshmen went, but there was enough in the class that we had our own table, and I went ever since. Sophomore, Junior, Senior. Maybe I went in the sophomore year. I don't know for sure, but I know I looked forward to it every year because they always had a top-notch band -- a nationwide band. Paul Whiteman, Glenn Gray -- I think Benny Goodman one year.

CBP: How much did a ticket cost?

AG: Oh, I don't know. It wasn't that high.

CBP: It wasn't that steep for a student budget?

AG: Yes, it was, but they all went. Don't forget, I think the tuition -- I don't know whether it was six hundred dollars a year or three hundred dollars a year. It was minimal, according to figures now.

CBP: The 1940 Synapsis, which was the yearbook for your class, showed a photograph of the staff of a student publication called Hidalgo. Does that ring a bell with you?

AG: It was called Hidalgo?

CBP: Yes. It was a photograph in your yearbook that showed the staff of a publication, and the name of the publication was called Hidalgo. It's a

publication I'm not familiar with.

AG: I'm not, either.

CBP: But it was from your class year.

AG: Do you have the Synapsis?

CBP: Yes, I have it right here. [Tape Off/On] So do you have any familiarity with the Hidalgo publication?

AG: No.

CBP: During your senior year, you belonged to the OB/GYN, the J. Francis Smith Neurological Society, and the Urological Society of which you were President. Please describe the objectives and activities of these societies and assess how successful they were.

AG: The motivation to join was the concept that it would give you more clinical information than they were getting through the routine classroom lectures and the clinics, and so on. From the practical standpoint, they were really a minimal impact. The meetings were very irregular. The biggest thing was you had a key. Each society had its own key, so you had more keys on a watch chain. They were ineffectual, really.

CBP: I'd like to talk now about the development of orthopedics as a specialty. Please provide a brief overview of the origins of orthopedics, including information such as when orthopedic surgery became a

distinct specialty from general surgery.

AG: Up until 1940, most orthopedic procedures, such as reconstruction, fracture treatment, bone tumor, was handled by the general surgeon. There were a few areas where there was specification with a man who denoted himself as an orthopedist. Their major impact on the healing arts at that time was directing their attention to the treatment of post-polio deformities, a variety of the neurological disorders that brought in paralysis or spasticity, and congenital normalities. The orthopedics began to develop as a well recognized specialty in the 1940s -- early 1940s -- and I think the first residency in Philadelphia in orthopedics was either in 1938, 1939 or 1940. I'm speaking of the medical -- entire City of Philadelphia.

CBP: Where was that first orthopedics residency?

AG: I don't know. I don't know whether it was Temple, because when I was a student, Temple brought in John Royal Moore from San Francisco. He was in the Shriner's Hospital out there. Temple was expanding its faculty at that time. They were bringing in well-known specialists. There were a few that were locally developed. Chevalier Jackson was a Philadelphian, who developed endoscopy primarily in

the esophagus and the trachea. But they brought in Royal Moore, and I think he may have started a residency program. Penn had a couple orthopedists before 1940, but I think they were general surgeons who specialized. The one we now named from the University of Pennsylvania, was Colonna. I think he was the first orthopedist that I recall who was designated as such. The first at Jefferson that made a name was DePalma. But that was later. That was after he came back from the Second World War, so this was in the latter part of the 1940s and 1950s. But orthopedics really started as a totally inclusive specialty around 1940, all over the country. There were a few people who were practicing solely orthopedics before that time, but only in various well designated subspecialties, as I say, such as post-polio, cerebral palsy, spastic paraplegia and the congenital deformities. The origin of the Dupont Institute down in Wilmington, was actually formulated as an orthopedic hospital, originally. Now it's a general hospital for pediatric surgery and pediatric disease.

CBP: Could you explain a little bit how orthopedics grew out of pediatrics -- the connection there?

AG: Well, most of the deformities were -- most of the

ailments that I've described -- cerebral palsy, post-polio -- were in children. Congenital deformities are in children.

CBP: Did the development of orthopedics as a specialty happen simultaneously in the osteopathic and the allopathic world?

AG: We were just a little behind. There was a man who was interested in foot diseases, by the name of Rothmeyer, when I was a student. He was also the Professor of Anatomy. But he was a general D.O. practitioner, who welcomed foot disease. Mechanical foot disease. The first real orthopedist was Eaton here, and I really don't know where he got his background. He primarily was self-taught. And that was in 1940. I expressed an interest to work with him as an assistant, and his response was, "We're starting a Department of Orthopedics, so we'll start together."

CBP: The next topic I want to talk about is the evolution of the orthopedics department here, at PCOM. Could you please describe for me the development of orthopedic surgery at PCOM, and in particular, the role of James Madison Eaton in the development of orthopedics here.

AG: He was a young general surgeon on the staff. I

guess he must have been in his mid-thirties at that time. I venture to say he was about ten or twelve years my senior. He expressed an interest in orthopedics and more or less, I assume, went through the various echelons in the administration that he wanted to be designated as an orthopedist. He did general surgery while I was with him as a clinical assistant, from 1941 until, I guess, 1943. Now, I was away then. I was with him from 1941 until 1942, for the fourteen months as clinical assistant. He was doing general surgery and general practice, as well as orthopedics, and he was doing orthopedics, and the big thing that was just beginning at that time was surgery directed for spinal disease and herniated discs. He did the first laminectomy there. So that his forte for years was as a spinal surgeon. But he was doing all sorts of orthopedics. Fracture work, and so on. And by this time, fracture became part of the armamentarium of the -- fracture treatment became part of the armamentarium of the orthopedist, rather than being with the general surgeon. There were still general surgeons who did fracture work, but that was diminishing -- stopping.

CBP: So we're talking about the early 1940s, as this

formation --?

AG: Yes, and by 1950, it was a well established specialty all over the country.

CBP: When did Eaton actually establish an independent orthopedic division here?

AG: Oh, he established a separate orthopedic division right that first year -- 1940.

CBP: 1940.

AG: I was a Clinical Assistant in Orthopedic Surgery. That was my title.

CBP: And that was a division of Surgery?

AG: Yes.

CBP: Did orthopedics subsequently become its own department, independent of Surgery all together?

AG: I don't know. While I was associated with it, it was always the Division of Surgery, because Eaton was not only Chairman of the Division of Orthopedic Surgery, he was Chairman of the Department of Surgery, in his later years.

CBP: How would you describe Dr. Eaton as an educator, as a clinician and as a lay person?

AG: Well, he was very warm, had a host of friends, was easy to talk to. Patients would swear by him because he just came over as if you were the only person in his life, and gave a tremendous

charismatic feeling to the individual that he's going to get him well. He didn't go out and guarantee or advertise -- that sort of thing. But he just could impress the patient, where the patient just thought, "Well, this is a disciple of God." He didn't bring religion into it, but that was the matter. They would just glow when he would come into the room, making rounds. He was very dedicated, he was well motivated. He knew his work as a clinician. He was excellent as a technology individual, as far as his handling in the operating room. He was an excellent mechanic, doing the work. He was very curious. He had an inquiring mind. Any book seller could sell him a book. They'd come in, he'd buy every book there was, and read it. He was a very heavy reader and he'd buy any new instrument that came along, willing to try anything new. He was very loyal to the people that started with him -- trained. I was the first -- when I went with him at the time that I wanted to go to Kansas City. I said I wanted to go there, and the reasons, and he didn't think I should. I said, "Well, I've already made all the arrangements. I'm going. I have my train tickets." He said, "Well, when you're finished, come back." And he did. He welcomed me



back and brought me on the staff. As an active practitioner, there were very few beds available. And at that time -- this is after I returned from New York -- there were maybe five to seven people on the hospital staff who were given allocated beds, one of his allocated beds he always had ten beds available for him. I'm just taking a hypothetical figure. If I had a case that needed surgery -- I was going to do -- I'd call him to take one of his, and he would give me the privilege of using one of his allocated beds -- he always had the facility available to me, until we had our own hospital that the Metropolitan group had developed.

CBP: Do you remember the bed tax at the Osteopathic Hospital?

AG: I remember the bed tax at Met. I don't remember it at PCOM. Whatever it was, I was involved with it. You know, you paid it.

[end of side one]

CBP: How would you assess PCOM's and/or Dr. Eaton's role in the development of orthopedic surgery within the broader context of the osteopathic profession?

AG: I think in the early days of the development of

orthopedic surgery and osteopathy, he had a preeminent role, nationwide. He was well recognized in the formation and development of the American Osteopathic Academy of Orthopedics. He was past President of that organization. And the American College of Osteopathic Surgeons. He was past President of that organization. His impact on the Philadelphia College of Osteopathy and the hospital was rather tremendous, in that he became Chief of the Department of Surgery, and actually, one of the most influential of the surgeons in the osteopathic profession, both here, locally, and nationwide. He was Chairman of the Board of Surgery -- that's the American Osteopathic Board of Surgery. In the early days when I was certified, we were certified under the American Osteopathic Board of Surgery, as orthopedic surgeons. We only had our own certifying Board, I guess, about twenty-five years ago, or twenty years ago, that became distinctive as a separate entity. He developed a residency program, turned out many men. There are orthopedists practicing now, using the concept of grandfather, great-grandfather -- they're the great-grandchildren, really, of Eaton.

CBP: What year would you say was when the residency

program started in orthopedics?

AG: I would be guessing. I can't give you an exact term because I didn't come through it. I came through as clinical assistant, then as fellow, and then I was practicing orthopedic surgery after that. I had my training in New York, and between that and the fact that I qualified for an osteopathic surgeon's license. At that time, D.O.s were not licensed to do surgery, except with special licensure. My D.O. licensure was fifty-eight in the entire state. That was still my number when I retired. I can't recall the exact date of origin of the residency. I assume it was about 1950 -- maybe 1949 -- because after me were two other clinical assistants that came up that way. There was Charles Brimfield, who practiced in York. Isn't that amazing? I forgot the name. It was Glen. Was there an orthopedist that you came across in your reading?

CBP: Well, there was somebody. Herman Poppe.

AG: No, no. It was before Herman Poppe's time. He was really number three. He was associated with the Norristown Hospital, which was called Riverview. Cole. Glen Cole.

CBP: He trained after you?

AG: Yes. When I left for New York, Brimfield and Cole

were starting to train. Cole had graduated a couple years before I did. Brimfield was in the class behind me. Cole was practicing both as a general surgeon/orthopedist. Brimfield restricted himself to orthopedics, solely, after his clinical affiliation. I think it was subsequent to those two. There may have been one other -- Salerno may have been a clinical assistant, or he may have been one of the first residents. And then after that, it was all residency. So we're speaking about 1949 or 1950, or maybe 1951.

CBP: But your fellowship with Dr. Eaton was 1941.

AG: Yes.

CBP: And that followed your being a clinical assistant?

AG: I started as a clinical assistant, and then, the next year, I was a fellow.

CBP: So you did internship, clinical assistant, fellow, then you got your M.D.?

AG: Yes.

CBP: Then you went to St. Francis for a residency, and then you came back?

AG: I came back as an assistant in orthopedic surgery.

CBP: And that was 1945?

AG: Yes. And then from that, I went up to -- when I really retired from teaching here, I was Clinical

Professor of Orthopedic Surgery.

CBP: Assuming we're talking about 1949 or 1950 for the official residency program in orthopedics, do you have any sense how that compares with other osteopathic colleges in the country, if, in fact, PCOM was at the forefront in training for orthopedic surgery?

AG: It would only be a matter of a year or two, because Detroit was also a development. Columbus, Ohio had a developing orthopedic program. But the first real orthopedic residency in the osteopathic profession was in Los Angeles. It ante-dated Philadelphia by a year or two.

CBP: Okay.

AG: It was during my internship, I think, that they built a separate entity on the Los Angeles General Hospital. That was the county hospital. And a referendum made a qualification that it was approved -- the funds approved, as long as they had an entity for the osteopathic building. So they set-up as part of the Los Angeles County Hospital, the Osteopathic Division, which was a separate building. And they had an orthopedic residency program going. This was based on a D.O. by the name of Jennings, who was German-trained. He came from a well-to-do

family and he decided he wanted to be an orthopedist and was sent to Germany for training in orthopedics. He may have pre-dated Eaton, or it was simultaneous with Eaton. But it would only be a matter of a year or two between who came first, and I think Los Angeles came first. I think then Philadelphia, and then Detroit, and Ohio, and then Kansas City got into it.

CBP: Once there was a residency program here, how did you train the residents in orthopedics? What was the program?

AG: The program was one where the orthopedic resident scrubbed on every orthopedic case, and at that time, in the early days, there were only two orthopedists who were working in the hospitals, from 1945 until about 1950, and that was Eaton and myself. Brimfield worked in York and Glen Cole worked in Norristown only. Metropolitan developed and I was doing orthopedics at Metropolitan. Cherry Hill developed, Glen Cole went over to cover the orthopedics there, and started to train a man named Kaufman. Glen Cole then died. He had a brain tumor. I took over with my first orthopedic resident, who trained with me at Metropolitan, a man named Lewis, Phil Lewis, and we covered Cherry Hill

until Kaufman qualified for his certification, and then we backed off, and he took over Cherry Hill. But the predominant thing was the training in the O.R. at PCOM, handling the clinics. Residents were in charge of the clinic. There was always an attending with the resident. They were given some teaching assignments for the classroom. They made rounds with the orthopedists. Whoever was coming in, they would make rounds with me, or primarily with Eaton. He had the real workload at PCOM. It was secondary to me, but I always maintained it out of the feeling of loyalty, to carry the clinics. He wouldn't come down to the clinics. He was just too busy for it. When I came back in 1945, he was completely in orthopedics. No other type of surgery whatsoever. That would be it. There were occasional exposures to other influences, but don't forget, at the beginning of the orthopedic residency training program here, we were still in a state of non-harmony with the medical profession. Gradually, we got the privilege of sending residents down, like the Dupont Institute, for a period of six months or a year. Originally they were simply auditing sessions. There was no credit given, except we would give them the credit for being exposed to

outside orthopedic training. Now it's common practice. They're all over the country. If they have a four-year program, at least one year is spent outside, in other institutions -- maybe even two years.

CBP: Could you please give me the chronology for the chairmen of orthopedics here, at PCOM. The names and, if possible, the dates in which that person served as Chairman of Orthopedics, beginning with Dr. Eaton.

AG: It was Dr. Eaton. The subsequent Chairman was Poppe, who always was his assistant -- actually, was his employee. After Poppe, I don't know who came.

CBP: Would that be Dr. Wynne?

AG: Yes. Wynne was brought down from Rhode Island. And then it's whoever you have now.

CBP: Do you know offhand what the dates were that Dr. Eaton chaired orthopedics?

AG: Get the date of his death. It would be 1940 until his death.

CBP: 1940 would actually be considered being its own division?

AG: I think so. Yes.

CBP: Well, Herman Poppe started in 1961.

AG: Right. That carried until his death.



CBP: Which was 1976.

AG: Okay. Then that's when they brought Brendan Wynne here. I think Bob Irwin was already here as Chairman of the Department of Surgery, was he not, at that time?

CBP: I don't know offhand. Could you comment a little bit, please, about Dr. Poppe and Dr. Wynne, and their roles as Chairmen of Orthopedics here at PCOM?

AG: I stopped doing surgery here within five years after they moved out here from the other building. I know he covered the surgery well. He had a nice practice here. He certainly did not have the charisma that Eaton had. He didn't have the personality, either.

CBP: You're speaking of Poppe right now?

AG: Poppe. Yes. He was satisfactory in the O.R. He was a good surgeon in the O.R., and that's about all I can say. Wynne had established himself in Rhode Island, I believe. Rhode Island or Connecticut. I don't know where he actually did his work. He didn't train in Philadelphia. He trained in the Midwest. It may have been Detroit or Columbus. And then he came down here, and I think he did a good job as Chairman. When Wynne was here, I wasn't giving classes. I just sort of severed my relationship. I was busy enough huckstering all the

other hospitals. I was going to most of the osteopathic hospitals, as well as covering Metropolitan, and I just dropped out of PCO. I think there was difficulty with getting operating time. Not the beds. We could get the beds. But the operating time was difficult. And it became a problem when you had other hospitals we were servicing between Dr. Lewis and myself. When Glen Cole died, my associate, Dr. Lewis, took over at Norristown. That's where Glen Cole was. And he also took over Bristol. Glen Cole worked out of there. The two of us took over at Cherry Hill, alternating. I had Wilmington. So we had quite a workload of our own. When one of us was away, you worked from six in the morning until midnight.

CBP: Starting in 1945, you began a clinical practice at the newly formed Metropolitan Hospital at 19th and Green Streets. Were you involved in the founding of that hospital?

AG: No. I was in New York at the time, when they actually developed the founding of the hospital.

CBP: Why was it founded, and by whom?

AG: It was founded by a group of -- I don't know -- twelve or fifteen D.O.s It was founded because beds weren't available for them. We're speaking of a

time when they could not get a bed and service their patient in a medical institution. If they sent it to a medical institution, that was the end of their patient. They just stayed wherever they sent them. They could not get a bed in PCO because the beds were allocated. This made for a very great feeling of dissatisfaction, so that many of the alumni have always been very cold toward the school and the hospital, and it's been maintained to this day. Many of my classmates resented the fact that they couldn't get an internship. As I said, very few internships were available. Detroit was available, Los Angeles was available, and, I think, Columbus. That was all. So that you had a group of malcontents who were here in the city of Greater Philadelphia, the City and the suburbs, and fifteen of them got together and organized, and bought this old private hospital, and it was really a far cry from what you conceived as a hospital now. We were carrying patients between floors to the operating room on stretchers. No elevator was available then.

CBP: Do you know what hospital it had been before?

AG: I think it was called Doctors' Hospital. I'm not sure. It was a private hospital.

CBP: A private allopathic hospital?

AG: Yes.

CBP: Has there ever been a positive association between PCOM and Metropolitan prior to PCOM acquiring Parkview? Was it ever a place where PCOM medical students or interns would get some clinical experience?

AG: The interns wouldn't come down. Students came down on rotation. The intern was really a house officer in the institution where he was an intern.

CBP: What has been your personal association with Metropolitan over the years?

AG: I came in -- I was the orthopedist. I was already finished in New York. I was practicing out of PCO. I'm trying to think of the time -- the first Chief of Surgery was a man named Herman Kohn. He found things difficult, politically. Not because of him, the machinations of the organization, and he resigned. I was the only certified surgeon in the hospital, so I became Chairman of the Department of Surgery at Metropolitan and Chairman of the Division of Orthopedics. I was the only orthopedist there, I guess, for years, until Phil Lewis was trained, and we were already at 3rd and Spruce when some additional orthopedists came on. Then, at the new Metropolitan, which is now a decaying modern

building, I guess we had maybe four or five different orthopedists. Five orthopedic surgeons on the staff there. I was Chairman of the Division of Orthopedics until I got hepatitis in 1984, when I stopped surgery. No, that's not right. I was Chairman of the Division until then. I was Chairman of the Department of Surgery until about 1972 or 1973, when a general surgeon took over as Chairman. I was on the Board of Trustees and committee appointments, and so on.

CBP: Are you fully retired now?

AG: Well, I had to go into semi-retirement because in 1984 when I got hepatitis, it was a Non-A, Non-B. It's now called Hepatitis C. Even though they permitted me to go back to work -- I was told I could go back to surgery six months after I got it. I wasn't working that whole time. I was quite ill. I didn't because I would always be considered a candidate for litigation. I never really got over it. I have chronic hepatitis from then until now. I gave up surgery, continued doing consultation work, and gradually, with attrition, I've lost many of the referring physicians, and continued until 1994, and then went into total retirement in January of 1994.

CBP: What were your greatest accomplishments as a clinical professor of orthopedic surgery?

AG: I thought I was a fair teacher, lecturer. My lectures were all visual, very well prepared. I had a good course in orthopedics. Dr. Eaton rarely ever came in to teach once I was back. He just didn't have the time. I think I influenced some of the men that wanted to go into orthopedics. I created the department at Metropolitan. We had many residents who finished there. I think we trained thirty men -- twenty-five or thirty men -- who have since trained men who have since trained men. [laughs] In other words, it has been handed down so that some of the men say, "You're my great-grandfather" or "You're my grandfather." That sort of thing. I had quite a number of printed publications, and that's about all. I feel I sort of did my work and don't have to feel that I didn't accomplish a life's work.

CBP: We talked a little bit before about the struggles for professional recognition for the osteopathic physician. We were looking at it from the standpoint of the government recognizing D.O.s for military service. At a closer level, how has PCOM helped its students and alumni obtain professional recognition and parity?

AG: PCOM alone?

CBP: Yes.

AG: Well, I think that they certainly have done a great deal to establish the satellite clinics in the low income areas. They have supported health practice for the people who can't afford it. They have put out good products, as far as many of their residents, and became Chairmen of Divisions in their specialties throughout the country. Many of them made names for themselves. Many of them have already retired who trained entirely at PCO.

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

AG: Putting out a good product. They have a lot of very good practitioners out there, both in the specialties and in general practice. They have directed their interests primarily in the last few years, into giving a general practitioner the prime consideration, 'if that's the graduate, we want to get out' rather than the specialist, which I think is good. We're just over-specialized. So that if you're a patient, and I'm now a patient, I can see the difficulty the average patient would have, where he goes to one man that says, "Oh, that's a skin rash. You have to go to a dermatologist." "Well,

if you need a bowel movement, I'm going to send you to a gastroenterologist." I can see the frustration that a patient can have with selecting a specialist, rather than going through a general practitioner, with a family practice. I grew up in a family practitioner's aura -- in that atmosphere -- where the specialist was called in rarely, and only when needed by the opinion of the general practitioner.

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

AG: Survival.

CBP: Survival as an osteopathic institution, or just financial solvency?

AG: Well, both. But as an osteopathic institution. The revolution that has occurred in medicine is so dramatic, since I've lived through it from the beginning of the old atmosphere to the present, it's such a tremendous transition, a tremendous revolutionary change, that medicine has become a business. It's like a utility or a railroad -- transportation. It's strictly business. And medicine is not controlled by the medical profession. It's controlled by businessmen.

CBP: Why is osteopathy, in particular, threatened by



that?

AG: Oh, I don't think osteopathy is threatened so much from the fact that businessmen are in control. They're threatened by the fact that if they don't produce economically, financially, with a profit, they won't get the support of the business people behind it. And therefore, they will lose their identification, really.

CBP: Do you see any concerns with the emphasis now in many allopathic medical schools, on primary health care, as putting more competition up against the osteopathic students, who have always been trained for primary health care? Does that become a threat to an osteopathic college of survival?

AG: I don't think so, because the medical profession still is putting out specialists. The average graduate is so obvious -- goes into a specialty as soon as he goes into the hospital -- the day of graduation. It's first PGY -- first post-graduate year. And that's in a specialty. In medicine, in gastroenterology, in cardiology, in orthopedic surgery, in plastic surgery. Whereas they come out of PCOM and the other osteopathic schools, as a general practitioner. With a small minority going into specialties. Now, many of our specialists have

gone in and become prime top-flight surgeons in allopathic institutions where they head departments. Same with Radiologists. But I think you're going to have less and less. I think that the osteopathic schools will predominantly -- to a much higher degree than even now -- put out the general practitioner.

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

AG: Not necessarily. I had a good professional life, and I really owe my career to the motivation instilled by these two men that I mentioned -- Otterbein Dressler and Eaton. I have some pictures. Most of them are personal, so I don't know whether they'd be of any value.

End of Interview

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