1997

Richard S. Koch Oral History

Philadelphia College of Osteopathic Medicine

INTERVIEW WITH RICHARD S. KOCH, D.O. (CLASS OF 1938)
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
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PERLOFF: Please state your full name, date of birth and place where you were raised.

KOCH:

CBP: Where do you currently reside? Your complete mailing address, please.

RK:

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

RK: I wanted to be independent rather than work for someone else, number one. Number two, I wanted to be in a profession where I could be proudly servicing the world. I had heard lots of testimonials and neighbors' reports of superior care -- better care -- more extensive care, more positive results by going to osteopathic doctors as compared to ordinary doctors, in those days, in my adolescence.

CBP: Had you ever actually been treated by an osteopathic physician?

RK: No.

CBP: Were any family members or others influential in your upbringing involved in the medical profession?

RK: In the family -- no. Neighbors, yes.

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

RK: Just the pre-medical course -- of only one year, in those days -- at the University of Alabama.

CBP: Was that all science courses?

RK: No. Liberal arts and science.

CBP: So it was one year of college education?

RK: Yes.

CBP: Why did you select PCOM for your education?

RK: The proximity, closeness, recommendations of the osteopathic doctors that I'd talked to, which were obviously Pennsylvania and Philadelphia located, recommended it. I considered it the most advanced in modern medical education and research.

CBP: Did you ever apply to other osteopathic schools?

RK: No.

CBP: What were the highlights of your educational experience at PCOM in the 1930s? Courses or

professors, for example?

RK: I was very impressed with the anatomy course by Dr. Cathie and Dr. Green. I had the fun of having little discussions with medical students at Jefferson and Temple, who I knew socially, and had the fun of seeming to excel in the knowledge of anatomy over their knowledge of anatomy, so I gained confidence in the increased intensity and accuracy of education at the Osteopathic College, and felt comfortable that I was equal or exceeding, excelling over allopathic schools locally. Dr. Cressman was an exceptionally mentally astute dermatologist and an inspiration, and Dr. Ralph Fisher and Dr. Victor Fisher -- Dr. Pennock, Dr. Drew, Dr. Erb, who was the Dean of the College and a chemistry professor. Dr. Weisbecker. I think all of the professors impressed me as being more than adequate. One way you would judge your adequacy is their answers to your questions. Whether they evaded questions or answered them, whether they contradicted themselves, which isn't impressive to questioning medical students. If a professor doesn't give them good,

direct consistent answers -- so those men impressed me, I think, most. Those are the ones who come to my mind first. I was elected President of the class. I got an internship at Philadelphia Osteopathic Hospital. Those were very impressionable to me.

CBP: I'd like to go back to Dr. Cathie, since he is the first one that came to mind when I asked you this question. Could you tell me a little bit more about your impressions of Dr. Cathie and the course that he taught?

RK: Yes. Number one, he demanded -- he let you know he demanded -- quality students and education, and you weren't going to sneak by him with bluffs. He went into anatomy intricately to impress you -- most intricately -- and in more detail than Gray's Anatomy emphasized. More detail than the medical students at other schools that I knew emphasized, with the emphasis on the fact that the body is nothing but mechanical elements -- gross and microscopic molecules -- emphasizing the mechanics of the body and how it influenced the function,

circulation and chemistry, and how posture and gravity -- symmetry and assymetry and "uprightness", so to speak, against gravity -- influenced the mechanics that the body depends on for efficiency. The biggest thing, I think, he impressed me with was the fact that -- as Andrew Taylor Still would say, "The rule of the artery is supreme," meaning that blood supply is so much a factor in the resulting disease, immunity and healing of a disease. Dr. Cathie emphasized that not one cell in the body got any blood for eating or breathing or excreting into. It's the serum lymph and the interstitial connective juices between cells that convey the nutrition and the elimination of poison, as an intermediary to and from the blood. Therefore, tissue tensions of the body -- tightness of tissues, shortness of one side of the body's tissues as compared to the opposite side -- symmetry or a lack of it, in other words -- enter into the efficiency of deliverance of nutrition and elimination of poisons from the cells and organs. Dr. Cathie would emphasize that you're going to be tested, and you better be prepared, and

he's not going to play any favorites, and he certainly did not. He would spring tests, which made you respect him and his efforts, and made you be prepared, so that you were always studying anatomy for him and yourself, of course. We as D.O.s excelled in anatomy.

CBP: In those days, were there bone boxes that the students would take home to study preparations of bones?

RK: No, we didn't have them. They were being developed at that time. But some students would buy their own.

CBP: They were being developed?

RK: Yes. They stayed in the lab.

CBP: When you were a medical student, were there any ceremonies at the end of the year for returning the cadavers for burial?

RK: No way. I never heard of that.

CBP: Okay. Because eventually there were. It was for medical schools throughout the city. It was a unified service -- memorial service.

RK: I didn't know that.

CBP: The families of the deceased were also invited to attend.

RK: Do you mean the cadavers?

CBP: Yes. Families of the cadavers.

RK: They knew the cadavers, do you mean? They knew who they are?

CBP: For those who did, it was a service to pay tribute to these people who had donated themselves for medical study, and there was a memorial service that was then conducted every year, and students -- medical students throughout the city -- would attend the service. But that might have started later.

RK: Carol, in those days, you see, during the Depression, you had indigents on the streets, and people were dying unknown, and they came from unknown sources and public hospital wards and institutions.

CBP: Okay. You had mentioned that Dr. Erb was Dean. I had thought that Edgar Holden was Dean during your time.

RK: You're right. You're right. Irb was Dean for a short while when Holden wasn't. But Holden was Dean

most of the time, but for some of the time -- my understanding was Erb was Dean and it may be that he just came in the summertime, when Holden wasn't there. Now it's coming to me. I think he was Assistant Dean or Associate Dean. I don't know.

CBP: Please share your recollections of Dean Holden.

RK: Dean Holden, I think, had less popularity associated with him than other faculty. Not because he wasn't a great guy. He was a great fellow, I'm sure -- and capable. He just had a personality and a little hardness of hearing which made it difficult for him to converse with people and put them at ease. I never saw him smile, I think. He was an excellent Dean.

CBP: Please describe how OMT was taught in the 1930s.

RK: By Dr. Soden, mostly. Not exclusively but he was head of the Department, and he would give us the anatomical basis on a blackboard and then books and via bone specimens, then he would lecture, and then he would demonstrate. And have associates to demonstrate in his department. They would take us into the clinic, on the tables, and we would examine

each other's spines, we would treat each other's spines as indicated. We would then watch him treat clinic patients, and then we would take over after we were felt to be adequate. His department associate would assign us students to take over the manipulative aspects of treating patients who would come in -- maybe on a weekly basis -- and we would treat their spines.

CBP: Did you first practice on each other?

RK: Yes. It was practice, within limitations -- yes.

CBP: How about the nursing students? Were they involved in helping you with OMT, as far as a patient?

RK: No. They would submit anybody -- let's say connected with the institution -- could go to any of the other doctors and get treatment, and I remember occasionally a nurse would come in for a treatment, and usually a staff doctor demonstrated manipulation. They were often assigned to a doctor.

CBP: At that time did you and your classmates truly feel committed to incorporating OMT into your medical practice, or was it viewed as a requirement for obtaining a degree that would let you practice

medicine?

RK: No, the former. We were exceedingly -- emotionally, scientifically and intellectually -- dedicated to the advisability, respect and benefits of manipulation. We felt that's why we were there. We went there to learn something different than ordinary schools were teaching. We were dedicated to wanting to know it because we wanted to use it. Now, there were a few exceptions -- student exceptions -- but the vast majority showed enthusiasm.

CBP: I just wanted to go back to asking you a question about anatomy -- as to how anatomy was taught when you were a medical student. How much of it was classroom lecturing versus demonstration or versus your actually doing things yourself in the dissection laboratory. What was the balance?

RK: It was an excellent balance, I feel. We got it didactically. The professor would make us go home and read Gray's Anatomy and come back and have to know it almost word for word. And then we would discuss it and take exams. So that's the book

learning part. Then we would discuss questions, if there were questions, confusion being resolved. Then the doctor would bring the parts of the body to the classroom, and show the model of it -- like a bone or a liver or a heart. Then, in the laboratory -- in the dissection lab, of course -- we would actually get into the body -- the human corpse, and dissect, and the prosector, who was a graduate doctor, concentrating on anatomy, would oversee us dissecting, and answer our questions, and demonstrate and point out things, and have us do as much as we could. If we couldn't understand something, he would come there and clarify. We literally dissected every inch from head to toes!.

CBP: How many students were assigned to a cadaver?

RK: Four.

CBP: Were there ever any instances where the students had difficulty making this transition to working on a cadaver?

RK: Emotionally?

CBP: Yes.

RK: Yes, but I think it was only for a couple of hours

or days. I was one of them. I couldn't eat meat for about a week. [laughs] Yes. The answer is yes.

CBP: Was there anybody in particular who was helpful in getting you through that?

RK: No. In those days, we didn't need anybody but ourselves, emotionally, psychologically and intellectually. No, there were none of these "nowadays support groups" for tender fragile minds.

CBP: It's my understanding that your clinical training, while a student at PCOM, started in the second semester of your junior year.

RK: Yes.

CBP: Please describe your clinical training and comment on the strengths and weaknesses of that part of the curriculum.

RK: Clinical training was in your white coat. That was great. You had a stethoscope in your pocket. [laughs] That was half the battle right there. [laughs] You felt like a doctor. And then you associated with the faculty in charge of clinics with about five or six doctors, who were graduates

and instructors, who were our overseers who demonstrated procedures. So we would go in and watch them listen to a heart, check a spine, check the skin. Do "complete" exams, et al. And then we would be indoctrinated into recordskeeping. We would have to watch him write-up the findings and the recommendations, and he would refer them to a specialist or for surgery or x-rays or special tests, etc., on each case. So a student was assigned for a certain number of hours a week to these sessions, where we would actually see a graduate physician diagnosing and treating patients off the streets, and we would learn how to do that. Then later, after we had done that for about a half a year, maybe the next year we would do it on our own, and then if we had a question of a confrontation or a problem, we would bring in the overseeing doctor. I guess, if I remember right, he would check the patient's record and talk to the patient anyway. Even though we had finished what we felt was a good job, he would oversee, to see that the patient was satisfied, and it looked to him like

we handled it correctly.

CBP: Did you feel you were ready to do this at the time?

RK: No, I don't think you should feel like you are, and I don't think anybody is. You should think you want to learn more -- you don't know it all.

CBP: Yes. Some of the clinical physicians -- Drs. Eaton, Pennock, Evans and Wagner -- do you recall these men, and can you share your impressions of them?

RK: Oh, yes. Wonderful, great men. I learned a lot from them. Eaton was very bright, and let us say he did not encourage debate or discussion after he had said something. Dr. Pennock would. Pennock was the chief surgeon of the Hospital. Everybody could talk to Dr. Pennock exceedingly well, and he would tell you what he knew, and he wouldn't be afraid to say, "Nobody knows," or "I don't know." Wagner the pediatrician, was very affable, capable and younger than most. Dr. Walter Evans was, in my opinion, a most competent OB/GYN specialist. And as a physician, he too, like Pennock, would discuss things freely, acknowledging he didn't know when he wouldn't know something. He would be very eager to

answer your questions, which were the things a student looks for for admiration and satisfaction from a professor. They want their questions answered with consistency. Dr. Lloyd was our radiologist and highly respected.

CBP: Was there anybody in particular whom you considered to be your mentor?

RK: No. The most admired, I guess, had to be Dr. Cathie, because he had such a seemingly unrecognized position, but an exceedingly important role in developing an osteopathic philosophy and an "osteopathic conviction. He was not a top political entity around there, nor social. But intellectually and contribution-wise, I could say I admired him most.

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

RK: We didn't assist in doctors' offices in those days, as I remember -- not our class. But we would go out and take care of people in the impoverished areas of

the city, delivering babies, treating hemmorhoids, Tuberculosis, taking care of sore throats and syphilis. There was a lot of syphilis in those days. We saw heart failure, diabetes, strokes, hypertension, gangrene et al. in various stages.

CBP: How did this end up being opportunities when you went out to their homes versus their coming into the 48th Street clinic?

RK: I don't know. That was kind of -- let us say -- an administrative decision as to who was going to come in here or who was going to stay home and have a doctor come out. The answer is, "I don't know." It may have been an economic thing. Maybe they couldn't get away from their house, nor afford travel and hospital and clinic costs. That was a very common situation.

CBP: Were there any organized outpatient clinics other than 48th Street?

RK: Not to my knowledge.

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

RK: No, I don't recall an OB clinic at 3rd and Lehigh. I do know a lot of the doctors wanting to do OB more

were out in the field -- out in various neighborhoods -- delivering babies. I do know that.

CBP: Do you recall what neighborhoods you were going to to see patients at home?

RK: Yes. South Philadelphia.

CBP: Not West? Not North? Just South Philadelphia?

RK: Some in West Philadelphia. I don't recall any North Philadelphia.

CBP: Did you have a car to be able to get around to see all these patients?

RK: No. Sometimes we took the trolley car, or we'd borrow somebody's car. Let us say, it wasn't as organized as efficiently and as optimally as we would like to. It was hit-and-miss and undependable transporation.

CBP: Please describe your rotating internship at PCO upon your graduation from the medical school.

RK: As I recall, there were about six services. One was obstetrics, one was surgery, one was internal medicine, one was emergency room, one was x-ray and one was pathology lab with autopsies also. Do you want to take one at a time?

CBP: Sure. I'd like to get a sense of what the internship experience was like.

RK: Yes. It was great, I thought. Some of us may have had an inferior complex regarding the numbers of patients and clinical experiences we would have. Once we got out of the College -- graduated -- you knew you had done well compared to other medical students in the community. Some of us got some of the highest marks -- examinations -- state boards -- compared to allopaths. We were confident that our didactic education was good. When we got into the internship, we had been told by allopathic sources, that our clinical experience was going to be less than in their facilities. That was so when compared to, say, Jefferson or Temple or Penn, because they have so many more patients. But by the same token, you only have eight hours a day -- or ten or twelve -- whatever you're going to spend down there, not sleeping -- and you used it well. You did just about as well as they did. Now, my point is that in taking x-ray service, you had to be there a certain number of hours, but you could also hang around

there more hours. Dr. Lloyd, who was head of the department -- he or Wheeler or some of the other doctors down there -- would teach you and answer your questions and let you hang around longer than your required hours of service. So beyond your required hours of service in x-ray, you could watch more x-ray is you would watch x-ray techniques, learn more about the importance of covering the screening gonads so the x-rays wouldn't hurt them. You could hear additional descriptions of patients symptoms, diagnosis, x-ray interpretations, and optimum film development, etc. So you could hang around longer, after your hours in all other services in our emergency room service. Patients weren't as prolific as at Penn or Temple, but we would see cuts and bruises and fractures and bleedings, abscesses, strokes, auto accidents, burns, self-motivation, knife and bullet wounds, drunks, et all. It was trauma mostly. 'Saturday Night Fractures' (wrist fracture) were common. We saw minor surgery cases like hemorrhoidectomies, gynecologic procedures, et al. We would watch or

help more experienced interns or staff doctors care for them as sewing things up, putting splints on and diagnosing, with x-rays and lab work. We got to do some of it ourselves after we had been there a while. We got to sew up sutures -- circumcisions, blood transfusions, things like that. Then in the obstetrics, we were in the six-week run in the obstetrics service. You were perpetually on the OB floor when you weren't sleeping. You'd get up or you'd be called in the middle of the night. Your hours were "always," and you would watch the delivery of babies and watch the accessory surgery that went along with some deliveries. You watched the caesareans, you'd assist at them, you scrubbed up.

CBP: What kind of schedule were you maintaining as an intern?

RK: Oh, boy. Supposedly eight hours sleep at night, and the rest was "on duty", then we'd be off at five.

CBP: Weren't you on call at night?

RK: Sure. That's what I'm saying. In other words, you could be called anytime. But supposedly, we were on

an eight-hour schedule. You start out with the idea you're on an eight-hour schedule and you're going to stop work at four or five. But then you're always called back to the emergency room or the OB or the floor for diabetes or an earache or post surgical problems or something like that.

CBP: How many nights a week would you be staying in the intern's quarters?

RK: Every night.

CBP: And how many of there were you?

RK: Seven first-year interns and two second-year ones, and then one third-year man, who had been there longer. In other words, about ten.

CBP: Did you have responsibilities for training medical students when you were an intern?

RK: Yes, medical students in clinics would come over to the Hospital a junior or senior, and watch things in the departments of the Hospital. So the intern would teach them what he could, and then the other graduate doctors would teach them even more.

CBP: As a first-year intern, was there any kind of hazing coming from the second- or third-year interns?

RK: No way. We weren't there for that at all.

CBP: Was there any special camaraderie among the interns?

RK: Oh, sure. No cliques or dislikes or favoritism that I ever observed.

CBP: I want to talk to you a little bit about your life as a student during this time. Not so much the educational experience, but just the experience of being a student. How do you think going to medical school during the Depression impacted your experience as a medical student?

RK: It made us, I believe, far more responsible for ourselves. There was nobody to fall back on, so to speak -- relatively little, except your parents. No governmental supports. You had the responsibility -- you were brought up through the schooling before and during medical school to know that -- look, you've got this job. Nobody is guaranteeing you a thing. You've got this job in your life, let's make yourself as knowledgeable and adaptable as you can.

CBP: Where did you live when you were a student?

RK: Elkins Park. With my mother for the first year, and then the second year, I roomed with two other

fellows in an apartment, and then for the last two years -- in an osteopathic fraternity house.

CBP: In West Philadelphia?

RK: Yes. Just down the street from the Hospital.

CBP: Were there particular student hangouts -- places the students regularly frequented for a drink or a sandwich -- that just came to be known as part of the PCOM student culture?

RK: No, not in those days. You didn't have the money to do anything like that. The closest to that description, Carol, was Paul's Deli, across the street. But nobody did any partying or drinking, I guess, except on weekends in the fraternity houses. But otherwise not really.

CBP: What were the highlights of your social experience at PCOM and in Philadelphia at that time?

RK: Well, sports mostly. A lot of people don't know that the College had a tennis team and a swimming team. And before I came there, they had other teams -- football and baseball. Some of us tried to stay in shape and enjoy sports as much as we could when we weren't studying. Then the College did have the

Charity Ball, which was a money-raiser, which we all were eager to go to in tuxedos and all. But they were the only social functions connected with the College. The Ladies Auxillary of the Hospital developed fashionable functions. Outside that it was just personal association with your old friends if you could get the money and time together to get together with somebody in Elkins Park or Jenkintown or West Philadelphia.

CBP: You were a member of Phi Sigma Gamma fraternity?

RK: Yes.

CBP: What activities did you participate in as part of the fraternity?

RK: Well, as President, I helped start a house. We tried to run a law and order thing. We tried to discourage rowdiness, disorder and liquor excess. We couldn't have ladies in there unattended. And we would have a few dances, parties or dinners. We'd have parties as often as we could afford and our energies would allow us. There was a recreation room down in the basement. That's something I overlooked in answering one of your back questions.

Yes, socially, we had fraternity parties whenever we felt we could.

CBP: Were those dances?

RK: Yes, that's right. A jukebox and a beer keg and dancing. Yes.

CBP: Did you say you got a new house started?

RK: You bet.

CBP: Was it a new building for the same fraternity?

RK: No. You see, the Phi Sigma Gamma did not have a house for a long time, and we said, "We ought to have a new house." So we did. What you do is find the landlord or the owner and ask them if you can pile in a bunch of guys as renters, and call it a fraternity house. In those Depression days, that worked. Then, pretty soon, we got a house where the owner wasn't in the house, but they'd get it inspected, and we were buying it by the month.

CBP: Where was this house that you started?

RK: Between 45th and 46th, on Spruce Street. We changed after a couple years to another house between 47th and 48th, on Hazel Avenue.

CBP: What kind of initiation was there?

RK: Well, respectful, serious one. No hazing or frivolity or adolescent stuff. You took a vow and listened to inspirational purposes for why the fraternity was to exist. Ideals in healing and loyalty were stressed, as were pledges to make yourself and the profession and society better. There was a little dark room. You'd turn the lights down in the room. This is kind of a tradition for fraternity initiations. You have kind of a spooky room. [laughs] People sit around and the ones that have already been initiated, sit around the edges. They blindfold a new inductee, and some of the others would lead him around the room and tell him this is what this and that stands for and symbols are used. It was all very good inspirational stuff, rather than degrading adolescent garbage and hazing, like so many of them can be.

CBP: I understand you were quite the boxer in the 1930s as Dick Wallace.

RK: Well . . .

CBP: Could you please tell me that story?

RK: I had the light heavyweight title at Alabama as a

freshman. Then I came to Philly, and a manager called me. His name was Carl Barrett, a real nice, black fellow. He had heard about me -- as a titleist at Alabama. He said, "Do you want to box for me?" I said, "Yes." Besides the thrill it was at nineteen years of age, it could help me earn some money through college. I signed the contract as Dick Wallace, and I used to go down to a South Street Gym. It was one block east, on Broad Street, off the subway stop. So anyway, after school I'd run down there and workout, train, box, spar, and have an occasional fight. You'd get fifty dollars a fight for a three-round fight. Then you'd come back and you'd study, you'd eat, and then to bed. And I'd play tennis matches and swimming meets, have to go down there afterward. We had swimming meets against Westchester State Teachers College and Villanova and others. Tennis against Haverford, Swarthmore, Elizabeth, State Teachers and others.

CBP: Two questions. Did the College know you were boxing? And why were you Dick Wallace?

RK: Well, you take a "ring name." I liked the idea of a

ring name instead of your personal name, especially if you're going into a profession. The manager looks at your name and says, "Hey, we want a different name." [laughs] He said, "We don't want Dick Koch." So we kicked it around and I said, "Wallace" (because that was an ancestral Scottish name that I admired.) I admired the Scots and their history. So the manager told me, "Okay, Dick Wallace."

CBP: Did the administration of the College here know that you were boxing?

RK: No.

CBP: Do you think it would have been problematic if they did know?

RK: Yes and no. Because I kind of sneaked it in gradually. For instance, I told Dr. Cathie. He knew it. And one or two other men on the faculty knew it. But I am surprised if the administration knew it. I never told anyone else on the faculty except the several doctors who took care of my broken ribs from a fight. [laughs] Dr. Cathie scathingly dissuaded me from continuing after ten

months.

CBP: Where were the meets held for the swimming team?

RK: [laughs] When it was a home match, so to speak, it was at 52nd Street YMCA, over around Market Street. When it was away, it was at the other college -- Westchester or Villanova or Elizabethtown or Haverford -- like that.

CBP: How about the tennis? Where were the tennis courts that you were playing?

RK: Garden Court Apartments, across the street. Is Garden Court Apartments still there?

CBP: Yes, it's still there.

RK: They had tennis courts there.

CBP: And they let you use them?

RK: Yes. I'm trying to think. You paid to get on there, as I remember -- twenty-five cents an hour. I'm not sure that Garden Court themselves owned it or leased it out to someone who charged you. So that's where we played at home. But so many of our matches were away because we didn't have good courts, or enough good courts. So we played at Villanova, Haverford, Elizabethtown State Teachers,

Westchester. And they had their courts, you see, because they were larger colleges in the rural areas.

CBP: This sounds like a lot of demands on your time.

RK: Oh, yes. I also used to earn twenty-five dollars about every month giving a pint of blood to post surgical patients when asked.

CBP: How were you able to juggle a full classload, the training for your sports, the matches or the meets, and getting your homework done? And a little boxing on the side?

RK: I didn't do it well. That's one reason I didn't do as well as I could have in the sports. I just couldn't stay in shape. I didn't like to train enough. So I was down to one hundred sixty-five pounds. I should have been around one hundred eighty. And believe it or not, we weren't exactly starving, but we didn't get the full meals that the kids get today. So I didn't stay in as good shape. It wasn't easy. We'd stay up later. For instance, my roommates and myself -- we'd sometimes only get four or five hours of sleep at night because we'd

study at night and get up early.

CBP: Was there peer pressure to be active in sports?

RK: No, I just loved them. But I did kind of feel a drive to try to perform and excel for my deceased father's admiration. He encouraged me to box. He died when I was eleven years old. So he was on my mind in sports.

CBP: Please describe any PCOM student traditions. For example, class rush or Junior Spree Day. Do any of these ring a bell?

RK: Not many in my class, Carol. No.

CBP: Were students still going up to Dufur Sanitorium for a faculty/student outing at that time?

RK: [laughs] Gosh, no. I thought that stopped before I got there. The last I heard they were going up there was through Dr. Paul Hatch in the 20s. The answer is no.

CBP: But I understand you served on Student Council.

RK: Yes.

CBP: What types of issues were you addressing at that time?

RK: Wait a minute now. We didn't have Student Council

as such in those days. Our classes would have class meetings -- but we didn't have a formal Student Council where all Class Presidents get together, if that's what you mean.

CBP: There wasn't a body that was selected by the students to be representative of them for the school?

RK: It was just the Presidents of the Classes.

CBP: Just Class Presidents?

RK: Yes.

CBP: Did you truly feel you had a voice in matters at the College?

RK: Sure, we did. In fact, as we graduated -- went through school -- we'd look at each other and chuckle and roll our eyes and say, "Boy did we make some changes. Did we change that College favorably," and the answer is yes, we did. Some of the people looked at us as a little bit revolutionary in our demands or our behavior.

CBP: What were some of those changes that you helped to implement?

RK: Well, we stopped the hazing.

CBP: What was the hazing?

RK: The hazing was that the freshman class coming in got picked on by the upper classmen to push us around -- let us say get one down and shave his mustache off and cut another one's hair. Generally, intimidate and humiliate us. And, of course, we were old enough mostly to know that that's harmless, but we'd resent it and didn't want it. So we fought back. So a fistfight almost started, and they pulled back -- the upper classmen pulled back. They got Dr. Mitch Brodkin down, who is a beautiful, lovely guy. He was a graduate student. He was a student instructor, and he is a handsome fellow. Mild and kind -- of small build and a real gentleman. He was a professor in the Histology Department and everybody liked him. The upper classmen got him down in the corner, and they were starting to shave his mustache off, and Louie Krebs and myself -- my roommate -- we rushed over and pushed the fellow away and said, "Don't you dare." Anyway, this was unheard of for a lower classmen class to resist upper classmen when it came to that. That was kind

of the culmination of a couple weeks before that of pushing us around and insulting us and telling us to wear a different tie or hat or coat, and we didn't. So none of us cooperated with them. So that made them extra mad, so we were going to have a fight. We had our dukes up. [laughs]

CBP: Well, I know in the 1920s there was a tradition that the freshman men had to wear dinks, which were like beanies.

RK: Where was that?

CBP: At PCO in the 1920s.

RK: Yes.

CBP: Was that part of any code for your years?

RK: No. No way.

CBP: Any other student traditions?

RK: Not traditions, Carol. I can't think of any traditions. But if you want me to develop and enlarge a little on how we think we changed it.

CBP: Yes, absolutely.

RK: We had class meetings, and as for suggestions of what the student body thought or our classmates thought we should do to make the place better, we

thought should be changed. One of them was we thought there was a gap between physiology knowledge and pathology. In other words, one professor teaches physiology, and okay, we understood that that meant to understand the function of the body. Then we had a class in pathology, which tells you the disease process. But it didn't show -- we didn't have a course that kind of fell in between there, to show you how one part of body function goes into disease. So we asked for a course in pathological physiology. I went to the Dean, and Dr. Dressler was head of Pathology, and Dr. Holden was Dean. Anyway, they put that in there. They changed a couple of classes -- the others, I don't recall -- to answer our request. They were very cooperative in changing the curriculum to help us understand what we're trying to learn even a little better.

CBP: Anything else on that topic for you? Changes that you implemented?

RK: I can't think of them right now, Carol.

CBP: How would you characterize faculty/student

relationships when you were a student in the 1930s?

RK: Good.

CBP: Do you want to elaborate?

RK: Mutually respectable and cooperative and communicative.

CBP: Were there any student/faculty outings outside of the academic setting?

RK: No way.

CBP: No picnics?

RK: Only fraternity-wise, Carol. For instance, we would have -- all the fraternities -- there were four -- would have their members who were on the faculty -- graduate doctors -- over to their houses to speak and give us lectures, and be much more informal. We invited the party. So there was that. Fraternal extracurricular associations. It was on a return basis. They had a golf team, too. I forgot that.

CBP: Were you on the golf team?

RK: No. But classmate Harry Kerr was. We had some pretty good golfers. Harry Kerr was an orchestra leader, too -- pretty well-known in Philly at that time. He was a titlest. I was just thinking of

him.

CBP: Women comprised roughly ten percent of the graduating class of 1938. In your opinion, how were the female students of the 1930s treated by their male classmates and their faculty?

RK: Very respectfully. They still said, "They were just women." [laughs] I'm being facetious here. In other words, they weren't liberating the women classmates as much today. But they were very respectfully and professionally treated without any rejection -- emotionally or otherwise.

CBP: How were they accepted by the patient community, from what you could see?

RK: Oh, very well. Very well. In fact, much to our surprise, better than many of them men.

CBP: Why do you think that was?

RK: I think probably they had -- I think they would put the patient at ease more. They would be less intimidating -- especially to your clinic patients who, I would guess at this moment, were probably a little intimidated by a male doctor, and when they had a female doctor, they would feel more at ease,

and they would feel less apt to be shown up as "being dumb," I would guess, and I would guess the ladies put empathy first and the men maybe considered an authoritative image first. I don't know. Am I making myself clear?

CBP: Yes.

RK: Carol, to get back on one thing -- if you want something on sports -- and I don't know why they do this. But the college never acknowledged that we had a Davis Cup player as a faculty member at PCOM in the 1930s, Dr. Carl Fischer. He and his son also were the father and son tennis champions of the nation. Dr. Carl Fischer was intercollegiate champion, also. Then there was a Bud Christensen. I don't know as much about him as others would know, but he was -- as I understand it -- a national intercollegiate tennis champion, too. Then we had the Eastern Intercollegiate Diving Champion on our swimming team.

CBP: Who was that?

RK: Ruggie Flocco. He was the Eastern Intercollegiate Diving Champion. He helped our team win so well,

and then Si Lubin was the best swimmer on the team -- and a Philadelphia titleist. We had a great record. I think we won all our matches -- I'm not sure. Anyway, Si Lubin is still alive, and he was an OB, and he helped get Dr. Lennie Finkelstein started, as I understand it.

CBP: Was there still a track team when you were here?

RK: No.

CBP: Because that was quite active in the 1910s and 1920s.

RK: Yes.

CBP: They were very successful, as well.

RK: That's right. And baseball.

CBP: Right. Right.

[end of side one]

CBP: Please describe the nature of your professional practice over the years.

RK: Carol, when I first started, because the war was on and my license in Washington was a physician and surgeon's license, I could legally do surgery. So I

started a general practice, referring patients to osteopathic hospitals -- there were only a few osteopathic hospitals in those days. I assisted a surgery with my patients with a lot of good surgeons. So pretty soon, in a couple years, I was doing a lot of surgery on my own after good training. Not extensive surgery, but some. I'd do tonsillectomies in the office and varicose veins in the office, and hemorrhoids and other procedures of minor surgery in the office. And family practice. I'd go out and do house calls. I amputated a diabetic's toe, cared for strokes, heart attacks, etc. in the home. Anyway, we made house calls a lot in those days because a lot of the doctors, of course, were in the service and away at war. The services were not granting D.O.s commission. So General Hershey, the head of the draft, said, "Okay, A.M.A. -- if you're not going to put the D.O.s with a commission, we're going to keep them home." So we stayed home and did very, very well because the A.M.A. had kept us out of the service. So I was home -- in the home in Olympia, Washington -- doing

general practice and surgery. I built-up quite a very satisfactory practice, including hospital surgery, office care and house calls out in the country and things like that.

CBP: I have a question for you. These patients that you picked up while the M.D.s were at war -- did they stay with you? I mean, were you the first osteopathic physician that they had gone to?

RK: Yes. We introduced them to the osteopathic philosophy which is ordinary medicine, plus attention to nature's immunity and emphasis on how you can help yourself at home and stay away from doctors and drugs by more natural methods -- so they were inbued with that. The answer is strongly yes. They stayed and referred a lot of people. When the doctors came back, the only reduction of services that I can recall was in seeing fewer surgical patients.

CBP: Was there any tradition of osteopathy in the Washington area?

RK: No, that's another reason why I went out west. I wanted to spread the osteopathic concept. I knew

they needed osteopathic doctors and I liked the idea of being a pioneer. That was kind of a part of your answer to your question -- why osteopathic medicine? I liked being a pioneer. The same reason for going to Washington. They didn't have many D.O.s there. And I liked the country here, too. I loved the west, mountains, lakes, trees, etc.

CBP: How did you accomplish this pioneering effort?

RK: Out there?

CBP: Yes.

RK: First, with patients and the public, I would try to correct common misconceptions of our profession as being limited, in our scope of practice. Many of the public and news media and other professionals viewed "osteopathy" and "osteopaths" as non-medical or opposed to medicine and restricted in medical education. This older terminology encouraged this. I would speak at groups and organizations and write articles for patients to try to educate the public about our scope of complete medical education and practice.

At our organizational levels (state and AOA) I, for

years, tried to get our profession to change our various organizations and institutions to no longer use the words "osteopathy" and "osteopath" for public consumption but to instead say "osteopathic physician" and "osteopathic medical school" and Washington Osteopathic Medical Association, etc. The states and colleges finally did. The AOA has still not done so.

CBP: How resistant was the allopathic community in Washington to the osteopathic physicians?

RK: On a scale from 1-10, about a 7 or 8.

CBP: In the 1938 synopsis, Dean Edgar Holden remarked, "The crowning glory of osteopathy is osteopathic research. The administration and the faculty are research-minded. Their attitude may be expected to be a stimulating factor and to impel consideration of research or elsewhere along unimpeachable lines." As a student in the 1930s, did you perceive this emphasis on research to be the case at PCOM?

RK: Emphatically, yes, yes. That was my biggest embarrassment with our profession and our school. We weren't proving what we knew to be true from

clinical experience. We knew certain things were happening and effective compatible with our philosophy, but nobody was proving it or showing it to convince our own faculty -- our own students, some of them -- and, of course, the allopathic and non-osteopathic scientific world.

CBP: Dean Holden's statement was suggesting that this research was going on at PCOM. Do you feel that it was?

RK: From what you just read, Carol, I didn't read that. He was saying that, "They were research minded" but it wasn't going on. He was saying we needed it. Do you interpret that from what you just read?

CBP: "The administration and the faculty are research-minded."

RK: Yes, but only "research minded."

CBP: "Their attitude may be expected to be a stimulating factor and to impel a consideration of research work elsewhere along unimpeachable lines."

RK: He's defending himself there, Carol, in my opinion. He knew darn well that we weren't researching like we should and used to. You see, they dropped

research in about 1936, when Dr. Long and Dr. Henry George, who were our research men, withdrew from the faculty. I don't know whether they were kicked off or withdrew. But anyway, they left, and there was no research after that, and Holden knew there should be research, and I interpret his words there as saying, "We need it." Don't lose our attitude -- yes, our attitude is there. But he didn't say we're doing it.

CBP: Do you feel that it was happening while you were there?

RK: Research?

CBP: Yes.

RK: The first two years, yes. Then they dropped it.

CBP: I understand that you have done work in osteopathic research.

RK: I think so. In a limited primative way, as "pilot studies."

CBP: Could you highlight your accomplishments in that area?

RK: Yes. I believe I proved to myself and patients that there is a very high incidence, by my records, that

minor spinal absnormalities of asymmetry and restricted vertebral motion contribute greatly to an organs immunity to aging and diseases: therefore to health and longevity. It took years of spinal exams and spinal x-rays and meticulous detailed and tedious history taking and observations of hundreds of patient's progress or lack of it, to conclude such relationships. I and other D.O.s devised economical corrective treatment programs for patients to do at home to help stop or reverse degenerative and disease processes. The results of such approach has been overwhelmingly gratifying to patients and myself. The economic savings in health care costs amid such results warrant much further respectable professional research. Grants and philanthropy and worldwide recognition and quicker generous endowments are destiend to follow. Highest quality students would seek our schools and graduate with an enthusiasm to proudly display their superior healing knowledge.

CBP: Do you think that the profession as a whole is now making significant strides in research?

RK: No, they're going the other way because they don't believe it enough. It's easy not to believe it because they're so darn many seemingly effective pills and operations out there to make them say, "Why? Why do it?"

CBP: I just have a few concluding questions here. In your opinion, what have been PCOM's most significant contributions to the profession?

RK: Good allopathic didactic education.

CBP: And what have been its greatest shortfalls?

RK: The ignoring of research -- clinical research -- on the osteopathic philosophy and the failure to graduate students with confidence in our philosophy.

CBP: Do you think PCOM alone is guilty of that, or do you think that is typical of all the osteopathic colleges?

RK: All, but in different degrees. It's typical of all of them because, of course, they don't believe it enough and there's too much easier effective treatment by surgery and pills and it's more tedious and less remunerative and they wonder if it's necessary. They commonly don't believe in it

because they don't practice it. So they don't know because they don't learn by research. But the answer is yes, I think it's in all our schools -- some more than others. California and Kirksville are trying to sustain it more.

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

RK: Renewed confidence and pride in the osteopathic philosophy by scientifically demonstrating its validity. We must institute respectable clinical research along the lines of proving or disproving the osteopathic concept.

CBP: Yes, sure.

RK: Research the osteopathic concept, and if it's wrong, we're a winner. We come out a winner. We go on record in the history of medicine and in the public eyes and in the scientific field as being the "heroes" revealed some more of the misconceptions of many in alternative medicine. If we show it's right -- and there's no question in my mind about that because I've seen it too much -- then we'd come out

as one of the major contributors in the history of medicine. One of the most important things in the prevention and cure of disease and especially economy in the practice of medicine. Because to go the route of what I'm talking about creates the valorous image of doctors who really do want to reduce sickness and costs of medical care. Liberating nature's own medicine and healing ability does this. So we have nothing to lose by respectably researching our philosophy. We come out a winner if we prove it's wrong and if we prove it's right.

CBP: I understand the proving it's right argument. Could you repeat for me, please, the proving it's wrong argument?

RK: Yes. If we prove it's wrong, we then show the world -- the scientific world -- that here we are, objective and smart and humble enough to acknowledge that something we and others have claimed is important and good -- and that chiropractors, naturopaths et al are claiming important and good -- is no good. And we have proven it. We have shown

that continuing dwelling on our approaches is a waste of money. It was a false concept.

CBP: Then what happens --?

RK: Lay those ideas to rest! People would stop spending money on manipulation of the spine, and expecting it to do some good.

CBP: But then, that's shooting the College and the profession in the foot.

RK: No, it elevates their image of honesty and respectability. They can limit their claims of distinctiveness and uniqueness to just the benefits to bones, muscles and joints (of manipulation) (but not to general visceral health).

CBP: You wouldn't need an osteopathic school if you're not going to offer that special technique.

RK: That's so. I'll bring in one more hair-raising suggestion. Then, if that were so, we should then amalgamate with the AMA -- because we have nothing different to offer. It's only a political decision then to stay separate and give ourselves different degrees. If we have something superior, let's find out and say it and stick with it far more --

financially supported by research and philanthropy. If we don't, climb aboard the AMA band wagon and stop the political in-fighting.

CBP: Yes. There may be a lot of resistance doing that.

RK: Sure, but it's selfish resistance born of insecurity. So that's where we would look good in the public eye if we say, "Hey, we're not going to be selfish." We're not going to pretend we've got something that we don't. We're not going to pretend we should be separate and distinct when we all have the same goal. It's only a political decision for the welfare of the people versus the power of those who have offices."

CBP: How have people here responded to that argument of trying to prove it either way?

RK: Mostly non-answers. I don't think most realize what we really have -- the value of the fact that we would show we have a superior contribution to medicine. The major leaders in the profession don't seem to give any consideration to it, and I don't know of any logical reason except that they don't have confidence in the philosophy. I think they

want to sustain the organization politically, to keep the status quo, whereas they don't believe all that much in the osteopathic concept, and naturally, neither would I if I hadn't seen it. And they haven't seen it because they've never used it and they haven't used it because they hadn't seen research to justify it and I don't blame them.

CBP: There's a lot of alumni who might question the value of their degrees if you were to prove that OMT doesn't work.

RK: I don't think so. They're still good doctors whose patients want them and their D.O. degrees stand for an education that made them real good doctors.

CBP: That's it for my prepared questions, although I have one question that has nothing to do with PCOM, and that's something I read about you and and an octopus wrestling.

RK: [laughs]

CBP: If you could just convince me that you really do that. [laughs]

RK: Oh, sure. I don't do some of the things that have been alluded to in the newspaper articles, some of

them are exaggerated though. I didn't alligator wrestle.

CBP: I want truth -- not fiction -- here.

RK: We had the world championship octopus wrestling contest in Tacoma for a few years, and I was entered in that. I never won the championship, but I love swimming and diving so much that I got into octopus hunting and wrestling. You can't legally spear them and you don't use a knife. You bring them up to surface by hand. Yes, I've done it, lots.

CBP: Is it catch and release?

RK: Yes.

CBP: You just bring it up to the surface? You don't kill it?

RK: Well, I have to say that the first few times we did it, we let them die on the beach because we weren't thinking ecologically. We often took some home to cook because we heard some wives were cooking them, but ours rotted because or wives wouldn't cook them. [laughs] So about the first year, we would take them home or let them die on the beach. Then, after that, we got more wise and empathetic, and we would

always release them -- yes.

CBP: Is this state-regulated?

RK: Yes, now it is. Because we abused it. Some fellows would spear and knife them, so they passed a law -- the state -- that you can't use a knife or spear them. What we also used to do was use mercury chloride crystals in a plastic bottle to squirt the mercury chloride liquid into their cave to make them come out, but we found that would kill them later on, so we stopped that.

CBP: Was this one-on-one octopus wrestling, or was it a group of you --?

RK: No, one-on-one. You always did it one-on-one. In fact, you have to get one pair of hands on the neck, below the head, in the neck and squeeze. Then you have to turn it or tumble it "inside out" so it's confused and you hold it at arm's length with the suction cups out, facing away from you -- far away from you. Then you'd take them to the surface and they're kind of "inside-out." They can't grasp you because you're behind the suction cup -- the suction cups side of the tentacles are away from you. It's

facing up as you go up, and you're choking them around the neck. That shuts off their circulation to get them to shore. They have three hearts and they're in their neck.

CBP: Is there somebody standing or swimming close by, in the event that the octopus gets you?

RK: Yes, yes. There should always be a "diving buddy" with knife with you.

CBP: Well, that's very interesting. It was the first time I've heard about that. [laughs]

RK: Jacques Cousteau came out to make his film on "The Octopus." He did it in Seattle, in the San Juan Islands in Puget Sound. A diving buddy of mine took him around. This is true, too. Cousteau wanted to photograph octopus wrestling, and he's got it in his pictures, and some of his movies that are selling. The one that he showed most is a dead octopus. They had a dead octopus -- and to make it perform for the camera -- they wanted to do certain things -- so they had the dead octopus and the diver is flopping it around and making him look alive, and the diver is looking like he's tired and getting choked, and

actually, he's in darn good shape. He's acting for the camera -- Cousteau's camera. [laughs] And the octopus is actually dead, so the diver has to keep flopping him around a bit to make him look alive. [laughs] Well, but I'll tell you one thing. I've taken his son, John Michel down to Grand Cayman Island and the Cousteaus are nice gentlemen.

CBP: Wow. Well, that's it for my questions. I appreciate your giving me this time on your vacation for the interview.

RK: Oh, it's been fun, Carol, and I appreciate it that someone is interested enough to get various opinions. You are to be congratulated and thanked.

CBP: Yes. Well, this will be a written document, that will end up being a permanent part of the archive here.

RK: Oh, great.

CBP: For research -- for my purposes and in the future.

RK: Oh, great.

CBP: Well, thank you very much, Dr. Koch.

RK: Thank you, Carol.

End of Interview

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