

1996

Robert L. Meals Oral History

Philadelphia College of Osteopathic Medicine

Follow this and additional works at: http://digitalcommons.pcom.edu/oral_histories

Recommended Citation

Philadelphia College of Osteopathic Medicine, "Robert L. Meals Oral History" (1996). *Oral Histories*. Paper 7.
http://digitalcommons.pcom.edu/oral_histories/7

This Article is brought to you for free and open access by the College Collections at DigitalCommons@PCOM. It has been accepted for inclusion in Oral Histories by an authorized administrator of DigitalCommons@PCOM. For more information, please contact library@pcom.edu.

INTERVIEW WITH ROBERT L. MEALS, D.O. (CLASS OF 1956)
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
October 25, 1996

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

MEALS:

CBP: Where do you currently reside?

RM:

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

RM: A classmate of mine, Dick Lynch -- while I was going to Lebanon Valley College--told me about the College and where he was planning to go to school. At that time I was living with my mother-in-law and wife in Lebanon, and she had a doctor who was an osteopath (Dr. George J. Moeschlin), and who she had used all of her life, and who I, after that, used also. It was because of those two factors that I decided on osteopathy. The fact is that I knew that I wanted to be a physician since I was a young boy, but I was not aware of the osteopathic profession until I got married.

CBP: Was your mother-in-law's physician a graduate of PCOM?

RM: Yes.

CBP: Were any family members or others influential in your upbringing involved

in the medical profession that made you want to be a doctor since you were a boy?

RM: I think my parents were the basic people that wanted me to become a doctor.

CBP: Was either of them involved in the medical profession?

RM: No, neither of those had anything to do with medicine.

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

RM: My first year -- actually, it's sort of interesting. I went to a one-room schoolhouse in Dillsburg, Pennsylvania. It's above Mechanicsburg. In that area we went to the eighth grade, and I finished my eighth grade, and another country schoolhouse over by Mechanicsburg -- Reitzel. Actually, not many people went to college from that area, but I knew even back then that I wanted to be a physician. I knew I had to go to Mechanicsburg High School, which was highly talked about as being able to develop you for college. Right at that time that I graduated was 1946, and this is when World War II ended. And so there were a lot of students that came back from World War II that went to colleges, and I was able to go to Huntington, Indiana -- Church College -- and spent my first year out there, and my grades were good enough to transfer then to Lebanon Valley, where I finished my undergraduate education. And then I came to PCOM.

CBP: Why did you select PCOM for your education over other osteopathic colleges?

RM: Richard Lynch, a fellow student at Lebanon Valley College, was a big factor in introducing me to PCO. He knew Dr. Young, knew their family, and I think to speak of Dr. Young, you know the prestige and the amount of influence that he and his family had. In fact, his brother, who later died of Hodgkin's Disease, was the physician for our first child -- my daughter. But I think Dr. Young's influence with Richard Lynch and his involvement with me and talking to me about it, and so on, was also a major factor.

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

RM: I think professors really stood out as a student because I thought that PCOM really had the top in the country, as far as I was concerned. They were good teachers. Dr. Angus Cathie was the anatomy professor, long since made to be -- well, almost everybody speaks of him as almost like a God. Then we had in physiology, Dr. Baldwin, a lot of the other departments. He and his brother in medical oncology. Dr. Lloyd -- Paul Turner Lloyd, who was the Chairman of Radiology, was a great professor, looked on by many as the leader of radiology, particularly all the Eastern United States, where most of the residents had come to PCOM, and PCOM was the first place to have a radiology resident. Dr. Lloyd formed the Board of Radiology with several other men across the country.

CBP: Is this within the osteopathic profession, or within the entire medical

profession?

RM: No, the osteopathic medical profession. He developed the American Osteopathic Board of Radiology.

CBP: James Eaton?

RM: James Madison Eaton. Yes. In fact, while I was in school, there was a publication in Life magazine of him being one of the third highest paid orthopedists in the country, and that people came from around the world for hip replacements, scoliosis and types of laminectomies and things other people couldn't do. And then we had a lot of obstetrical physicians. Evans, who the College is named after. But besides that there is Herman Kohn, who was both a surgeon and an OB. There was Lester Eisenberg, who was given that award last year for his teaching efforts. For surgery we had Dr. Young. That was one of his younger times, when he was very prominent in the surgical field. I think the other thing was that most of the professors really were tied into the clinical side, except for a few, like chemistry and physiology. But they still became involved in the clinical side with different things -- the internship, and programs that went on. So I think that a small select faculty that was like a family -- Victor Fisher in medicine, Dr. Daiber in medicine. I'm not sure that unless you're in a smaller institution that you'll ever be able to appreciate the closeness of the family and the involvement that whatever things come up that -- you can also talk to them like a family.

They would not always agree with you or vice versa, but you didn't go around hating or disliking because I think they were all gentlemen and finesse. I think number one, we all felt that we would like to have a big hospital and a lot of involvement with patients to a greater degree than in the small setting that we were in. So the clinical role in those years was mostly your senior year, when you got out on the floor in the clinics. But you had three years of didactic training. So I think that good, sound professors -- and with classes of a hundred students, which all could be in a small room, which was a little tight, but nevertheless, you knew you had the professor's eye on you all the time, and that they may call on you. Of course, I should also mention Dr. Nicholas and Dr. Heilig who were teaching OMT. I don't know whether he was part-time then, but he previously had been a professor of the Department, and he and Dr. Nicholas were main figures in the osteopathic side of the picture. If I hadn't thought a lot of them, I wonder if I would remember all their names today. And maybe only because it was such a small school as compared to today, where we have two hundred and fifty students, and many professors where -- today, truthfully, when I got to meetings, I really can't recall all the names. Now, maybe to the undergraduate student, they will have those same impressions that I have today, and it might be because they're the step-ladder for us learning to move to the next step, and understanding what's going on in medicine. And each one of those steps are

related to both the didactic and the clinical.

CBP: Was there a relationship with the faculty outside of the classroom or the laboratory or the clinic?

RM: Limited. Limited. When you got to the resident level, then you would be invited to the Chairman's home sometimes, but during the school year, we would have Founder's Day, and the one nice thing I liked about that was that all the professors wore their robes and came to Founder's Day. I still would like to see that go back. That's probably old time, but it showed the academic component of the faculty, and then the students and families and friends would come. The other highlight of getting together was we usually went down to the Union League at the end of the year, and this is where faculty appointments, re-appointments, and where you were moved up in the academic procedure. Most people liked that, and I still have a lot of people who say they miss the fact that we don't have that night together, but it's because of the size, I'm sure.

CBP: That was a student/faculty night?

RM: Yes. That was towards the end of graduation, whenever the awards would be handed out, and the residents would be introduced and told who's advancing, or if you were Assistant Professor and moved up to Associate Professor, or moved to Professor. It was sort of a time of the year that sort of tied things together because now we have dinners and so on, and we're supposed to just

have talking with each other. I think that's always important, but I see how frequently how older people such as myself, don't stay around and talk a lot. Sometimes I'm not sure we have a lot to talk about, like we did when there would be advancement to go and congratulate everybody, and talk back and forth. It's good you got that. I thought that was a very good time.

Occasionally they would have some other dinner/dance like this, with the students, or something like that, but that's about the extent. Not much different than it is today.

CBP: Do you remember the Frosh Social?

RM: The Freshmen Social?

CBP: Yes.

RM: No, I do not remember it.

CBP: There's a photograph of it in the exhibit now, with the Class of 1956. It was a photograph from September of 1953, showing the freshman dance.

RM: And we also had a rather large dinner/dance that had been a continuation from the 1940s, I guess, or 1930s, or earlier, when I think like what we're going to try to have at the Year 2000 or something like that -- a dinner dance, where you brought in a band, or people that spoke, or Bob Hope.

CBP: Well, there was the Charity Ball that was a fundraiser.

RM: Charity Ball. That was mostly before 1960.

CBP: So that was still going on into the 1950s?

RM: Oh, yes. But that really wasn't a fundraiser at that time, when I was a student. That was just a continuation of the Charity Ball, which was almost, as I recall, a dinner/dance for the faculty and staff. Like a staff dinner/dance -- more of that order. But it was faculty and staff. In later years when we stopped having that, we went to the dinner/dance and we never saw as much involvement with the faculty. Now, after graduation, Dr. Rowland used to have most of the office people, and the chairmen of departments -- sometimes vice chairmen -- have a dinner at the Union League after graduation. And the Board Members. That was another thing where we got together with the Board and administration on that one particular evening. But the one you just said --

CBP: The Charity Ball?

RM: No, for our class -- 1956. Do you recall where that was?

CBP: It looked like it was probably in the auditorium at 48th Street.

RM: Oh, okay. We did have things like that. And then Christmas. We would usually have the same as they do today with the students, where they would have their roasting and their fun night before Christmas. In the earlier days, we would even have choirs sing. We would have music and singing for Christmas. And then the roast became the more prevalent thing, rather than a Christmas night, where Santa Claus came and gave the children presents -- like that. And then we had all the fraternities and one sorority, which were

right there, one street down. There was always a lot of activity at all the fraternity houses.

CBP: What was that activity? Could you describe it, please?

RM: Yes. We had Log and Phi Sig, which were mostly organizations of members that like to have parties. They really liked to have a lot of parties. But the good side of it was they would have an educational almost twice a month, where they would have different speakers come in and talk to them, and then they'd have banquets at the end of the year. The meetings for Atlas were more of didactic meetings rather than having a lot of parties. Like they used to say that Phi Sig and Log were the party fraternities. Atlas was somewhere in between. They had a group of students that -- oh, some of them were more serious. Some of them liked to have parties, and maybe should be thrown in with the Phi Sig. The women's sorority did not go very long, and they had a lot of financial problems. They had a few parties at their house, but I think the biggest thing about the fraternities was that when you had all those fraternities there, a good percent of the class belonged to one of them, and it gave them a greater closeness with their group of people, and you would find that you really sometimes would go down for lunch down the street, or they would -- after the educational, they used to play some cards or drink a beer down in the basement, or something. There was a lot of togetherness in the fraternities and the sororities.

CBP: What fraternity did you belong to?

RM: Phi Sigma Gamma. I later became one of the faculty advisors for a good many years.

CBP: Where is Phi Sigma Gamma today?

RM: It's over on Washington Lane, which is, I guess, about fifteen minutes from here, in Germantown.

CBP: Are students living there?

RM: Yes. About seventeen students live there. My latest report was that there are seventeen students in the house. One of the things it does for the students, too -- when you say, "What did they do for them?" Provided low-cost housing. Now, even at this time I can hardly believe that \$170-\$180 a month. Now, where can you get a room or an apartment or something on that order? When we went over at 48th and Spruce, the rents were four dollars a week, and went up to six dollars a week. And you just think of how many students were able to get through school with less debt and so on, where we didn't have all the loans that we have today. So I think housing was a very big part of it. Maybe bigger than what we give credit. This also gave the chance for the people that live in the house to get involved with those that lived out in the community in other areas.

CBP: Where else did students live during the 1950s if they did not live in a fraternity?

RM: Well, there were a lot of apartment buildings around the College, and I think most of them stayed in places within fifteen minutes walking or trolley car of the College. That used to be a pretty strict part. They didn't want you scattered out too far, as far as getting to and from. And we didn't have a big parking lot for everybody to drive. Yes, I think that most -- now, you know that there's always someone that's going to live further -- but they lived in the general community of 48th and Spruce Streets.

CBP: When and why did fraternities at PCOM begin to wane?

RM: Well, I think when we went to a two-year basic science curriculum and third and fourth year clinical at school. The students were only there for two years, and then the next two years they were scattered throughout the Commonwealth in clinical rotations. Prior to this time the students did all of their studies and clinical practice at 48th and Spruce Streets. Therefore, four years at the fraternity allowed more experienced leadership and time for involvement. They just didn't get back to the campus. They weren't around. I think that when we changed the curriculum to the two years, only Phi Sig and Log survived.

CBP: We've recently added a few wooden boxes called bone boxes to our archival collection. Could you please describe how these boxes were used by medical students, and also why and when this practice was stopped.

RM: Well, I don't know when it was stopped, but when I was a student -- and for a

good many years after that -- you received a box of bones that would give you the skull and the back -- particularly the cervical dorsal lumbar spine, or certain segments of it -- vertebral bodies -- a rib, and then a femur, tibia and fibula, humerus, a wrist, and maybe a foot at times. They felt that examining these structures allowed the student to be able to appreciate it better in the clinical setting. If you said, "What does a shoulder look like?" and you saw the head of the humerus was rounded and smooth, and you could take it out of the bone box. In OPP, when they talk about the movement of the vertebral bodies of the spine, sometimes it's hard to conceptualize. What do you mean that their coronal or sagittal facing relates to how you move. But you could take those bone boxes, and many times, some of the segments were even wired together. So you could see how the facet joint separated and bent forward, how they rotated when you turned the spine from side to side, and when people talked about the true pelvis, where you had the pectineal brim, where the baby's head would go through, and so on. And where are the ischial spines? You can look at the pelvis and see it, and it's a little different, just looking in the anatomy book.

CBP: How did this tie in with the anatomy dissection laboratory?

RM: Well, in the dissection laboratory -- when they would have exams, they would sometimes have a table where they just examined different osseous structures and correlated them to muscular attachments. Either in a cadaver

or separate structure to ask, "Well, what is this groove or mark on the femur, where the muscle attachments were." Or, in the skull in neuro, they would say, "What's this opening at the base of the skull?" I think -- and when your looking at the eye -- the orbit -- of course, today, they have so much video and so on -- the three-dimensional and so on -- that it makes it a little easier, but it's nothing like looking in there and seeing how that relates to the nose, the maxillary sinus, and the different sinuses and the pillars of the face because you could actually see how the different pillars would be protective of why your face didn't just crush, and you had an entry to it, and so on. So I think that -- now, I might be wrong -- but I think a lot of students could look at them and it would remain with them most of their life. I think there's no one -- if I'd say 'femur' as a doctor -- that couldn't almost imagine that their femur in the bone box -- what it looked like.

CBP: If you had about a hundred students each year, where did a hundred sets of bones come from for the bone boxes?

RM: They were obtained from cadaver specimen by the Anatomy Department, I believe, a practice which was developed by Dr. Angus Cathie. They turned in at the end of the year, and they'd be used for the next year.

CBP: You don't know when they started doing this?

RM: No.

CBP: Could you please share your recollections of working in the 48th Street clinic

as a medical student?

RM: Well, as a medical student, I really was not sure of the role that the clinic had in preparing you for the next step. A lot of the time you talked to a patient and let them tell you what was the matter, so it was an initial step of getting to see the person. I didn't think we had much supervision, there wasn't even always a supervisor around that should have been there. There would be a different physician, you'd find somebody to talk to. And you would talk to each other. They didn't have a lot of conferences. They had a few. Probably the best part of it that I thought that I got something out of, was the residents would come for specialty clinics. That's like if you had a female for a vaginal examination, or for obstetrical care, and the only problem is usually they could only get six or eight people in that room, so it was limited to whether you were able to get in or not. And the same with the cardiac, when they'd be listening to heart sounds and so on, trying to teach even in a group of that size by the resident. "You see this? This is what this is," and so on. It never really seemed to me to be a strong point in my education. I think that the thing that I got out of it more than anything else was doing manipulation on the patient. Now, I did, for lack of knowing what to do next, maybe, as much as anything else, and I shouldn't make a statement like that, but a lot of times the only thing I was armed with was, "What can osteopathy do?" You would check the thing "Yes, if I give you a treatment. Let's see if your blood

pressure actually does come down." And, "Yes, I could prove that you did by giving an osteopathic treatment. Do you have a cough? I'm giving you treatment to the thorax." And spinal pain -- a different treatment. So I guess indirectly, it almost made me look for ways that the osteopathic technique could be used for my caring for -- most of the patients were chronic.

Occasionally you would have an acute situation, but most of the ones, when you would look back on the chart, they had been coming back, coming back for the same thing over and over again, and would almost tell you, "This is what the doctor gives me that helps," and many times you'd say, "Well, let's stay with it." Something of that order. After my graduation as a student and as an intern, I thought I had an excellent experience in the clinics because I tried to teach the things that I thought wasn't happening in the clinic before, like getting the students together and asking them, "What was your patient? Tell us why you ordered this." Different things. We would have the morning conference. I learned a lot by being involved and reading their charts and getting involved. And I think somewhere in that time period there was more accentuation on more involvement of morning conferences, and involvement with the students, rather than in just wading in it. So as an intern, it was -- to me -- a big, helpful thing because I was really trying to find out when the students came to me, "What about this or that," or what you did. I don't think today the interns get in the clinics.

CBP: I don't know.

RM: I'm not sure, but I always thought that was a good time for me.

CBP: What do you remember about the North Center Hospital? For instance, the neighborhood, the building, your experiences and responsibilities?

RM: Now, that was just the opposite of 48th and Spruce Street. You were given more latitude and responsibility in the patients' care.

CBP: Why was that a different approach at that hospital?

RM: I'm not sure. We had a different group of supervisors. Supervisors that really wanted you to go ahead. They didn't really want to have everybody standing in line, asking, "What do I do next?" or so on. So you found out that very quickly you would talk to others, and others of your class. There was much more of a chance of running into more acute situations, too. Things where people brought in children that were really sick, and adults with problems, and so on. I think the ones of us who were over there thought of it like we were down in the dungeon. It was a stone building. We had our clinics in the basement. Our tray department was down in the basement. We even had one back room that years ago, they used to use for when inebriated people would come in. They'd show them in the "tank" so to speak, over night. And the next morning see if they were okay to go, and they'd go. But it was in a neighborhood where we were seeing more acute things. Probably a larger black population, too, than 48th and Spruce Street. But we found that very

good because we saw so much more acute things. And safety -- we were always fearful.

CBP: How did you get to that hospital from West Philadelphia?

RM: Mostly by automobile.

CBP: Did students typically have cars to drive back and forth?

RM: Yes. A lot of them would, or they'd go with somebody else. A few would take transportation with the trolleys and so on. But most people, I think, got over by going with somebody else, and then you tried to park within the walls. There was a big brick wall the whole way around it, like Girard College, but not nearly as high. There was continually -- even staff doctors parked out in this street frequently, and they would have their cars broken into and things stolen from it. But when I was a student there, the fear was not that overwhelming. You just knew you didn't go outside the wall. You stayed within the hospital grounds, and knew that seemed to be relatively safe.

CBP: What, if any, practical experience did you obtain outside the hospital and other clinic settings? For example, home deliveries or assisting in doctors' offices? This is while you were a medical student.

RM: I have to say almost zero. It was against the rules to be out in those offices, and so on. Now, there were some of the students that did it. And I think that perhaps I may have visited a couple of hospitals, like over a weekend, where

you would do a history and physical, or help move a patient, or something of that order. There was one boy in our class that even bragged that he operated on a gall bladder and an appendix in one of the small hospitals. So I think it varied from people that were more aggressive, and being willing to take a chance in going into a lot of the neighborhood hospitals and so on. And most of the hospitals we got to go into, had to be very small ones, for the most part.

CBP: I wanted to talk to you a little bit more about student life. We did get into some of that earlier on. I understand you were married during your years at PCOM.

RM: Yes.

CBP: What was the norm for students during the 1950s?

RM: Well, surprisingly, a lot of times we'd have students over to our house for lunch or dinner, and we would go to other students' houses. During exam periods, the different groups would all go to different peoples' homes. "We'll study at your home tonight," or vice versa. So in my particular group, we had about six to ten people that were very close, and there was always something interacting somewhere within the group, and I think -- in Phi Sig that year, we had twenty-six members from that class that were in the fraternity. So we had a lot of closeness in the group. Occasionally on vacations we'd go to Atlantic City or to Easter holiday or something go someplace, but for the most part, it was done right within the homes and the neighborhood of

Philadelphia.

CBP: The socializing?

RM: Yes. There and at the fraternity. Even the women's group would come and prepare food at the fraternity while we were having our meeting, and then afterwards, we would party for a couple hours. Oh, it's a great thing.

CBP: Were you unusual in being married at that time, or was it common then that the guys in the 1950s were married?

RM: I think that of the group that I was a part of, there were very few that were married.

CBP: Why do you think there were so few women during your time at PCO?

RM: Well, I believe it was similar to many medical schools. We were going through the period when there were a lot of people who did not feel women should be in medicine, and I don't know where that came from. But they would take a token admission of one or two women in a class, and because that's the way it had been the year before -- unless you go way back to the beginning when there was a class, it was almost fifty-fifty. But for the most part, there was a question -- "How will the women do in internship?" "What will their role be? Will they get married and actually practice medicine?" There seemed to be a male chauvinistic type of experience. We didn't even have many women on our staff. A few. One in mammography. I think she's still over at New Jersey school -- Masterson -- unless she just recently retired.

But she worked in the clinics and in mammography, for breast screening. We had another one that was Dr. Sivitz, that died with pancreatic cancer, that was a token female that was supposed to be very excellent. But for some reason or the other -- as you know, Johns Hopkins, up until sometime recently -- ten or twenty years -- I don't know -- did not allow any women in their school. And you say, "Why?" It's hard to say. It goes back to the stories of women in early medicine it was almost impossible. They wouldn't allow them in.

CBP: Although PCOM has the tradition for a very long time of welcoming women into its classes.

RM: That was pre-war.

CBP: Pre-World War II?

RM: Yes.

CBP: Right. From the start of the College, up to the Second World War.

RM: Yes. During certain years I understand there were more women students, but during the 1950s and '60s, I believe there were less women at PCO. And I've often wondered that the Administration and so on was not a part of that decision-making, that there had to be a reason for that, and it probably was somebody in Admissions or so on, that didn't feel that that was the thing to do.

CBP: What was the Undergraduate Academy of Applied Osteopathy to which you belonged when you were a student?

RM: I belonged to a society that is interested in promoting osteopathy and learning more about it, because I think every student's question is, "Can't I learn more? How can I find out about it? Do I get the practical things that make me know how to make a correct treatment -- a correction?" And anything that allowed you to learn more of these techniques. This was much like the fraternity, too. It was a big thing -- the fraternity. A lot of people say, "Well, you learn your osteopathy in the fraternity." They had the people come in and say how they treated osteopathy in their office. They'd show them the corrections, let them do it, get involved with it earlier, hands-on approach. And so the Academy -- and then I went to some of the national Academy meetings, and you could see the depth of the study that was going on, and I think it was something to say that you wanted to know more about that area.

CBP: From the 1910s through the 1930s, organized athletics was an important part of student life at PCO. For obvious reasons, there appears to have been less emphasis on sports during the war years of the 1940s. Based upon your experience and observations, how would you characterize student athletics in the 1950s and in subsequent years?

RM: Well, in the 1950s, Dr. Rowland formed a basketball team. And even Dr. Melhorn, who is on the Board of our college right now -- he was very active with that group, and there was a good many of the students that played on that team. I think if you asked Dr. Melhorn, it was one of the highlights of

having a good basketball team. But when you went beyond basketball, you'd have touch football that people would play at fraternities sometimes, or when they got out to a picnic, or something of that order. But beyond that, no. Not much. Occasional baseball game. Dr. D'Alonzo was always a big baseball fan and so on, but we didn't have organized athletics beyond the basketball, to my recollection.

CBP: Has that changed since the 1950s?

RM: Oh, yes. When Hale Peffall came around -- he started the rugby, and then basketball was even continued more, and soccer to some degree. I'm not sure -- today, even -- if there's any formal baseball group. Football -- only sporadic. But beyond that, Hale Peffall would have to give you the history of it. To me, the students will talk about the rugby team win and what they've done, and I know several times I went out to a soccer game -- I took my son along, and he loved it -- where they were playing another group. So within the groups that play sports, I do think there's a lot of closeness within those groups of people.

CBP: On the subject of radiology, could you tell me when radiology became a specialty?

RM: I think it was in the early 1930s-1940s.

CBP: How was it treated before it was considered a specialty in the 1930s, because there was radiology earlier than that?

RM: I don't know.

CBP: Did the specialty develop simultaneously in the osteopathic and allopathic schools of medicine?

RM: Yes, I think so. I think that our Board of Osteopathic Radiology was started earlier than the allopaths.

CBP: Do you know what year that was?

RM: No.

CBP: Please describe the history of PCOM's Department of Radiology, beginning in 1926, with its founder and first Chairman, Paul T. Lloyd, D.O. (Class of 1923).

RM: Dr. Lloyd was made the first educator of the American Osteopathic Association who got special recognition for his educational program. Dr. Lloyd was involved with the American Osteopathic Association, Pennsylvania State Organization, and with the College, and he had the first fellowships in radiology at PCOM. And Dr. Hobbs just died; he was another great figure in radiology. He died at ninety-three. Dr. Lloyd died at ninety-five. Hobbs was at Columbus, Ohio. He was his first fellow in radiology, and then one of the other fellows was from Detroit, Michigan -- Karibo. Karibo is a great name in our profession. He has a son living yet who is an osteopathic physician. But he and Hobbs and Lloyd and a great doctor from New England who is still alive, and a couple of people -- Henderson from the

West and a couple others -- formed this College of Radiology. And they were very proud that they had their own members take the exam to be certified in radiology, rather than grandfathering themselves in as a first beginning. Dr. Lloyd established himself as a leader, the first President of the College, and so on, throughout the profession. And when something from the College, etc., came up, Dr. Lloyd was the person to contact. So he developed a residency and training program.

CBP: Did that start as a fellowship program?

RM: It started as a fellowship, and then it went on to a true residency program.

CBP: What was the distinction between it being a fellowship program and a residency program?

RM: A residency was a program of education accepted by a specialty college with certificates by examination. A fellowship was training for a specified period of time by a specialist.

CBP: At PCOM, when did the program transition from a fellowship to a residency?

RM: I should be able to answer that for you, but I'm not sure that it was up after World War II.

CBP: It was after World War II?

RM: I think it was after World War II. Pam Smith of AOCC could supply details.

CBP: What else could you tell me about Paul T. Lloyd? How would you describe him as an individual?

RM: He was a strong, motivated, knowledgeable person considered an authority in medicine. He was a true clinical radiologist. He always knew an explanation of why things happened, and could go in to depth. Where other people looked more superficially. And I think that's one of the things that made him so strong, that he also knew the patho-physiology, the laboratory. When I was a resident, and someone would have severe abdominal pain, we would stand and look at a film from one to two hours, and talk to the surgeon, the internist. And that was the great day where you had all the aspects of medicine coming together to discuss the case, and try to arrive. We didn't have CT ultrasound or any of those things. We just had that x-ray of that abdomen. We had to say, "Well, what is the thing that is most likely -- what chemistries did you do? What does that mean?" We had to really get into depth in the understanding of things that could lead to the type of complaint that the person had. He was very dogmatic that things could only be the right way. No second reason. It had to be the correct way. And for that reason, in the days that he was Chairman, he would really be able to be very strong in his discipline of the staff and faculty, and I think many feared him as much as had reverence for him, also. Many of them will recall the periods of that. He said between three and five were dictating. "You can't come into the x-ray department. Close the door." He was strong enough to make that stick. So that in their department, I could have put a blindfold down and go in, and if

they said, "Go over and get me a hemostat," or, "Go over and get me the equipment for doing a certain procedure," it had to be laid back in the exact same position. Very rigid. He had continual classes. He was a good educator. He'd go over the things, and really try to make you see it and understand it. Not just jump to a diagnosis, and not be able to understand why it is that, but what are the things that lead up to it, and everything like that.

[end of side one, tape one]

I'm continuing the discussion of the Radiology Department. One of the things that impressed me with Dr. Lloyd was that when he would be a speaker at an AOA or a radiology meeting, the place would always be packed. Everybody wanted to hear what Dr. Lloyd had to say. He was very proud of his involvement during World War II with the Atomic Energy Commission, and with having a meeting at the College, where they were involved with the fallout and the care for what the physicians should know for disaster preparedness. He was secretary of the American Cancer Association of Philadelphia. At the College, he developed a program with a grant, I believe \$30,000 per year, where they would divide the student groups up into about fifteen students, and then they would have the student from the

year before present that segment of class, and it would always be basic physiology and the discussion with the class. "What's a BUN? How would that relate?" So to understand all of the mechanisms, and he continued that until we came over to the City Line campus, and at that time the oncology program sort of fell apart because there were so many things happening, and they did not allow him to bring that same program over, and they didn't give him space. I think there were too many things going on. I think it's a type of program that even if today it was enforced, it's what they talk about small group -- small group learning. And they, themselves, asking the question. "What does this mean? Why should we know this? What is this genetic? What does this test show?" But Dr. Lloyd was a small man. He loved golf. He always wore a little button of his involvement with the golf tournaments, and so on. I guess that he believed in education, and the faculty. Very strong in the faculty, and the role of the faculty in the educational program, and so on. Very strong faculty person.

CBP: Was he approachable by the students?

RM: Yes, most students found him approachable. Some of them were fearful of him because he would ask them questions they didn't know the answers to, which he felt they should have. But almost any place you go, there will be students that said, "Yes, I know Dr. Lloyd." Yes, I think it was an overall great response he had with students.

CBP: An historical fact I'm wondering if you can clarify for me. I saw one reference that said that the idea of having a department of radiology here was the idea of Dean Edgar Holden, and that Dr. Lloyd implemented that. Have you heard anything about that, or where the idea for the department germinated?

RM: No. I believe you should discuss this with Mrs. Lloyd.

CBP: What would you highlight as the achievements of Lloyd's successor, John J. Gilligan, D.O. (Class of 1954), who led the Department from 1962 to 1973?

RM: Dr. Gilligan did a great job in the years that he was here. He was a person that believed that he was responsible and took his chairmanship responsibly for doing what his contract said--that he would see that radiology was done in the best fashion that it could be. So he therefore worked very hard. We didn't have many faculty or staff, and he would work until the work was done. He left because of things that are not really discussed -- his sickness. In his family, he always told me that none of his brothers or sisters or families, lived over the age of forty, and I can't say this -- I can only surmise - - that with him developing the diabetes, which was very high, it probably had a big factor in his making the decision that hard work, under-staffed, and in those days, radiology was growing, growing, growing because all the new equipment and so on was coming out, and he was the one that brought in the nuclear medicine aspect to the Department, and promoted the angiography.

So he really did his part in developing it. The reason he became Chairman was political. Between Dr. Barth and Dr. Lloyd continuing after he was sixty-five. I think that it is difficult to say where Dr. Lloyd would have taken the Department in those same ten years.

CBP: Was there a mandatory retirement?

RM: At sixty-five, that's what they initiated at least on him.

CBP: When did that start, having a mandatory retirement age?

RM: When I was on the faculty in the early 1960s, that was still up until the 1970s.

CBP: It started in the 1960s?

RM: I know it was present. I don't know whether it started. But they felt for a long time that at sixty-five, a person should retire.

CBP: Is there a mandatory retirement age currently?

RM: No. And I'm not sure -- you see, in that time we were going through another era of not having a lot of whole-time faculty, and he was one of the whole-time faculty. The whole-time faculty, of course, was handled differently than a private practice because there you couldn't say, "You have to stop practicing surgery or medicine or so on." But if you were an employee of the College, then they could tell us that sixty-five is a mandatory age.

CBP: Please describe the major developments in the Department of Radiology under your leadership from 1973 to 1991.

RM: Well, I guess one of the first things to come into the Department was the

development of ultrasound, and bringing ultrasound into the Department of Radiology. Dr. Raymond Ruberg, a neuro-radiologist, had gotten a piece of equipment from a research grant to study the ultrasound of the carotid arteries. And for one reason or another, never utilized the equipment. One of the first things that I accomplished was getting Dr. Ruberg and the College to utilize that ultrasound machine, and you know where ultrasound has gone since then. That was getting up towards the beginning of the ultrasound. The next thing I would say was the CT scanner.

CBP: When was that brought in?

RM: 1978, I think. Before that there was another thing. Dr. Gilligan had gotten the Picker Company to give us x-ray therapy and develop cobalt here at the new institution, here in the hospital, where at 48th and Spruce Street, all we had was orthovoltage, which is about one-fourth of the energy as moving up to cobalt. I think another thing that I was able to get was bring the four million electron linear accelerator, and bring us up-to-date in a type of equipment that would give good therapy at less harmful effect to the patient. The next thing was the CT scanner. I really worked hard to find out what scanner was good, and then secondly, to get the medical profession to allow PCOM, an osteopathic school, to have a CT scanner. Because the thoughts were that only the larger medical schools would be able to have it. So I spent two to three years in combination with Dr. Rowland and the staff of the

hospital, grass roots politics, to be approved by the HSA for us to have the CT scanner.

CBP: What is the HSA?

RM: The Hospital Service Administration. Federal rules say who can and who cannot -- or did say who can and who could not -- have new procedures or new equipment. So I think we were the thirteenth approved in this City of Philadelphia. We even had meetings over here in our own hospital of people coming in, and I remember there was a "no alcohol" clause." But the evening that we had all these big-shots of HSA and from all of the hospitals around, Dr. Rowland allowed wine to be served with the other hors d'oeuvres, over in the staff room. The black physician who died of breast cancer, who was even suggested to be Mayor of Philadelphia if she wouldn't have developed the problem. A woman doctor -- I'll think of her name later -- she came to the committee meetings, and a lot of our patients from the neighborhood came, and it's hard to look back and see how much fight it took to just get approval, and then after that, they only approved us for so much money. So we had to get a piece of equipment that would fall in that price range.

CBP: How much was the CT scanner?

RM: Five hundred and eighty-five thousand dollars, I think it was.

CBP: Where did you get that money?

RM: Well, at that time, the money came from the hospital administration, where

third party payers, the state, etc., will reimburse costs. I'm not sure of the actual things, but that's how the monies for any new equipment had to be approved, and there was a certain replacement by the state each year, and so on. But we got the CT scanner, and we got the first four generation CT scanner in the City of Philadelphia. I was very proud of that. People from Jefferson would come up and look at our machine, and monitor it, and see what it did. They later bought a fourth generation scanner themselves. The next thing -- we had a few years when we had patients referred from all over the city, which made me believe that if you have good equipment, people will refer you patients. If they say, "Hey, this is the latest. We know what's going on there." You can do certain things with that. Just think, before that time they had water bags they put around your head. Do you remember those days?

CBP: No.

RM: The water bag -- because you had so much artifact. And then we went to the recto-linear scanner that would zigzag around and cut out some of the artifacts, and you didn't have to have the water bags around your head. Then they went to the abdomen, and then they went to the circular -- the whole way around, the third and fourth generation, the way they are today. So the achievements, the development, and up to the place where we're starting to get rid of artifacts, and so on. The next thing was to try to bring in MR. We

finally succeeded in bringing MR to the campus, in a trailer. But I never succeeded in convincing the institution to purchase the MR. But I think that the high cost of it was one of the things. My other achievement, I think, that is the one that will be remembered by more students and so on, is the teaching program which I developed for teaching radiology in 1973. For a small group, fifteen to thirty students, teaching them for three to four weeks, continuing how to interpret x-rays and understand what should they order, not have to order always the most expensive. But if they understand the films, then they'll be able to order more appropriately, and know when they wouldn't have to go to something more sophisticated.

CBP: At what point in the curriculum did the student rotate through your four-week course?

RM: Third year. During their third year, I had one month of each group of students. We had twelve groups of students, and so every month we have a new group of students. The students, I think, come to us -- like, in this last group we had eighteen from PCOM, and we had two residents, an emergency room and one in podiatry. We had five students from New York School, two from Florida, and usually we'll have from Kirksville or Kansas. So we have students come from all over the country. It has been a very good program for people to relate to.

CBP: Are students coming from all over the country just for your radiology course,

or are they doing other coursework, as well?

RM: Just for my radiology course. Now, I think there are other courses in the hospital that some of the students come to, like cardiology, I think, is one of them. There are other programs that are well known, but I'm particularly one of those fortunate groups to have students. In fact, we are filled up almost over next year already. There's a continual application, and our biggest problem is to say, "If I go over thirty students, I'm losing the effect of small group teaching."

CBP: Of the thirty slots that you have, how many are filled by PCOM students?

RM: Usually 18 to 22.

CBP: I think that was the idea of there being more room here, at City Avenue, to accommodate more students.

RM: Yes. The classrooms at 48th and Spruce in the 1970s had gotten terrible. Noise across the street, and the trolleys going by that you couldn't hear. Regular classrooms.

CBP: What were some of the other major developments during your tenure as Chair of Department of Radiology, up until 1991, and then we'll discuss 1991 after that.

RM: One of the things that I was proud of was when I started out, I think we had one or two residents. And during my program, we had moved up to nine residents, and I had moved to the place where I could have a resident on a

service for a whole month or two months, and that they could rotate so that they could get a lot of training in that particular area for that month period. The second thing I was proud of was that I had convinced administration to allow me to have more faculty to cover a larger number of specialty areas, such as ultrasound, angiography, MRI, CT, nuclear medicine and neuroradiology. That was always a tough one. That was a headache because as soon as they would do it, they'd be offered a job to make more money and move out. The same with ultrasound. A specialist in neuro-radiology and nuclear medicine. So it allowed me from the days when Dr. Gilligan was here, that we only had three radiologists. So you didn't do much more than bread and butter radiology and diagnostic radiology. You did a little bit of angiography. Didn't get much into invasive radiology. So as much as I accomplished in that period, I almost lost, because it was difficult without having a depth of faculty to cover all the specialty areas, both for financial reasons and availability for the amount of salary we could pay, or even offer to have enough specialists to cover our areas. And I think that was the one thing that was the continual battle, to find enough of financial assets to go ahead with the program.

CBP: Is there anything else you'd like to say about that time period between 1973 and 1991, about the Department of Radiology?

RM: No.

CBP: Please describe the restructuring of the Department in 1991 that made you Academic Chair of Undergraduate Radiology.

RM: Well, at that time, Dr. Tilley, who was President at this institution had left, and Dr. Finkelstein had become President and appointed Dr. Popky as Chairman of Radiology

CBP: What was Dr. Popky's relationship to the department?

RM: He was Chairman of the Department of Radiology at Medical College of Pennsylvania. Politically they wanted to get a new Chairman over at Medical College. So he was looking for a job. We were looking for a way to meet our needs of subspecialty, and it fell together. With his moving here, Dr. Finkelstein appointed him to become the Chairman, and I become more involved just with the undergraduate education.

CBP: Is Dr. Popky a D.O.?

RM: M.D.

CBP: So he was brought in to chair the overall Department of Radiology?

RM: Yes.

CBP: How was the graduate program administered within that context?

RM: We still reported to the administrator, which is now called President of the hospital. I don't think there was any real changes except the responsibility now for Dr. Popky and his group, to make contracts with Graduate Health Care Systems, rather than in the past it would have been with PCOM.

CBP: How has the sale, in 1993, of the City Avenue Hospital affected the Department as far as organization, access to equipment and student education are concerned?

RM: Well, the student education has been separated. The undergraduate students over here, under my program.

CBP: Is that completely outside of the hospital?

RM: Yes.

CBP: They do not do radiology in the hospital?

RM: No. Everything currently is over at 4190, and they talk about building a new area in Evans Hall for me, for the new classroom setting, and then moving us over there.

CBP: How are they learning about the equipment that's installed in the hospital, while they're in a classroom environment?

RM: In varied methods through classroom lectures during the first two years and clinical rotations. The technicians do procedures for obtaining images. Physicians and radiologists relate to and interpret images.

CBP: You've mentioned how you started, in 1973, the smaller size teaching groups. Could you describe how medical students -- undergraduate medical students -- were taught radiology during your time as a student, in the 1950s, and any changes in the approach to teaching radiology until you introduced the small classroom situation in the 1970s?

RM: Well, what would happen would be that in your fourth year, or as an intern, you would be assigned as a student of that hospital a certain time in radiology. And the student would then watch procedures, listen to the doctors, give them the report. That was the way it was done in ninety percent of the hospitals in America.

CBP: So for you as a medical student, you didn't have classroom training in radiology?

RM: Oh, we had classes in the College talking about what radiology will show you -- like x-ray of the lungs, x-ray of the stomach, and so on. We did get a tour to go down into the x-ray department and look at the equipment -- just walking through -- and they did show us fluoroscopy. But basically, most places just had it as a student would go into the department, and they complained we'd go in and we'd stand on one foot and then stand on the other. You would watch somebody. Sometimes you would get to go into fluoroscopy, sometimes angiography. You would go in and listen to them report. But they really felt it was an unproductive period of time, that most of the time they were standing around, and not getting to do anything. Just stand and yawn and wink, while they're talking on the phone, going to the bathroom, and a million other things. And you're saying to yourself, "Let's get on with it. Let's get some reporting done, or something that I can see something happening." It was bad. Even today, many of the hospitals do not

have a program on for teaching students much about x-ray, other than their casual acquaintance had gone through. Even less than in the O.R. room. There, you at least could stand and look at the surgeon working in an area that you usually couldn't see anything in. Dr. Lloyd, in his later years, really felt that the program that I worked with -- and even had him teach in -- really was the best way to try to teach students, and he was really pleased that it was a part of our program here, at the school. And that means more to me, probably, than many of the other boards and other things because his recognition that this was a good way -- another person in the United States, Dr. Lucy Squire, developed a program for the M.D.s which I copied off of in a way, and I went up to visit her down at State University. She spent three days with me, and she even let me stay in her studio apartment while I was at the school. She talked continually. Philosophies and concepts, and her name is very well known in the M.D. profession -- and I think in the D.O., too, because she also believed in the small class size, and that was where I got my idea. And with her help, someone developed my own program, and has continued with it.

CBP: We talked about the small classroom program. Have there been any other significant changes in the radiology curriculum since the 1950s?

RM: Oh, yes. We no longer teach physics. Can you imagine the students sitting there listening to the physics of photon, gamma ray, beta, and how does

radiation -- radon today -- how does that affect you? I'm sure that's important. They know the word 'radiation.' You don't have to know the formulas and all those things. The other thing is that most recently -- this last year -- we no longer give a separate class in radiation oncology, but now it's with the group effort under Dr. Goldstein, where we used to teach particular groups in that. Back in the 1960s we had x-ray anatomy that went almost a whole year because they had anatomy two semesters, and then we had two semesters of diagnostic. So the amount of classes in the college setting had been reduced to about one-third of what it used to be. The didactic lectures. Now there are more attempts to educate students to order images after careful study of need and of only appropriate studies for cost reduction and more specialized studies.

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

RM: I did an internship at PCOM. Then I took a 3-year radiology residency and a fellowship for two years in radiation therapy under Dr. Lloyd at PCOM. And with different conferences, and going to different hospitals for short periods of time. But mostly it was here at PCOM.

CBP: Please describe the evolution of the radiology residency program at PCOM since the 1950s. What hospitals and clinics have been used for resident training?

RM: The residency program in radiology -- is that what you're asking?

CBP: Yes.

RM: In radiology, everything was done at PCOM up until probably the 1980s. Somewhere in those years we started allowing residents to go to fellowship programs, particularly in CT or in MR or in angiography -- or even pediatrics -- things which were not strong at our institution. I'm not sure when we started the rotations of two three-months in pediatric radiology at Children's Hospital -- it had to be in the 1980s, I think -- sometime in the 1980s -- that each resident had to go to Children's Hospital Radiology Department. I think at first it was two months, and then it went to three months. As the years went up to the MR, we would try to get the residents to go in one of the programs that they selected in MR, and not more than six months of a year did we like them to go out into fellowship training. We tried to keep it under six months a year. Since Dr. Popky has taken over, he sends the residents to - - I think it's a Graduate System Hospital -- so that they now rotate within the Graduate Hospital, as well as the pediatric, and I'm not sure where else. Not much different except that now they're within the Graduate System.

CBP: In your opinion, does training or practice for an osteopathic radiologist differ from that of an allopathic radiologist?

RM: No.

CBP: Are there any distinctions?

RM: There are some areas where we may pay some more attention to postural,

structural areas that, when we take the x-ray, that the osteopathic physician may look at it to evaluate for treatment, etc.

CBP: What, if any, significant research has the Department of Radiology participated in at PCOM?

RM: You're talking about just here, in recent years?

CBP: From earlier years, as well.

RM: From the earliest years, Dr. Lloyd and Dr. Long did an in-depth study on the motions in the cervical spine, and published a book on it.

CBP: Do you know when this was?

RM: I think it was 1938 or 1942 -- something of that order. I have a copy of the book in my library, and I can give you an exact date. He continually over the years did different types of research tied in with other departments, whether it's surgery or medicine or pediatrics, where radiologically we would become a part of the system, but frequently didn't get credit for it, or partial credit at times, because we were doing the imaging of the patients in the study, and were contributing on that basis. The biggest research, I guess, was the residents' papers that were produced each year, where they would study different areas that were relatively new or new, and then submit that to the AOCR and AOA. I think we were mostly clinical research. I think that's the word. There was no real in-depth research in the labs in like of that. I did promote and was helpful in getting an x-ray room over in Evans Hall, where

they could use x-rays and do research with animals and x-ray them. But we never did anything of any real significance. It was mostly the surgeons, urologists, something of that order, where they would be working on dogs. No, I think most of the research, in terms of papers and so on, would have been residents and conferences at the AOA, and like of that.

CBP: Please describe the Department's involvement with cancer treatment.

RM: In the early days, Dr. Lloyd was thought to be a leader in knowledge in radio-therapy. In his graduate training he went to Sloan-Kettering Memorial Hospital every week for a number of years, and became a leader in his knowledge in radio-therapy in our profession. With that, he had the orthovoltage equipment, which is two hundred and fifty thousand electron volt energy, and that was at 48th and Spruce Street. The radio-therapy for cancer has continued to the present time. Dr. Lloyd did much work and research on the treatment and diagnosis of breast cancer.

CBP: On a personal level, what do you think has been your greatest accomplishment as a practitioner and a teacher?

RM: Teaching radiology to students and being part of a small group lecturing program. Becoming a chairman of a major department at PCOM, and being allowed to develop its educational program. I can feel that I'm really helping the physician being able to understand an x-ray. Many of the people believe they should only understand how to order it, and not to really understand it.

CBP: In addition to Drs. Lloyd and Gilligan, and yourself, which other radiologists at PCOM, if any, warrant recognition for their contributions as teachers and/or practitioners and why?

RM: Dr. Aline Swift -- she's now deceased -- but she was a member of our Board after she retired. She was a nurse during World War II, and when she was accepted into the residency program, she was the first person here that the government paid program with her involvement as a World War II nurse. She was what you'd say when people fit together. Dr. Lloyd and Dr. Swift were an unbelievable pair. He was like the doctor that knew everything, and she was the enforcer, as the nurse, or the nurse radiologist and an intelligent physician. She saw that the work was done. She saw the residents and learned how to report correctly. Dr. Lloyd would not even look at a case if we didn't have every bit of history. If he would sit down, and he would say, "What is a certain chemistry?" And we'd stand there, tongue-tied. "Oh, God. I missed that one." He'd move to the next one, and he wouldn't report that case. And it then became Dr. Swift's job to report it, and she would get the pile of films together after he left and say, "All right. Now we got to get this work done." [laughs] He was a purist, but she was the one -- the enforcer to get it done. And I remember in my own training, when I finished my residency and became staff, I was sent over to 20th and North Center -- 20th and Susquehanna -- and I brought the film back and started asking her a lot of

questions. She said, "No. You're now on staff. You've got to start doing that." She said, "If you really have a question, I'll help you," or something. But that's the way she was with all the residents. She made them learn and understand that there's not going to be somebody just standing there, telling you this is what it is, and that's what it was, and so on. When we left 48th and Spruce Street, she managed 48th and Spruce Street Department until they closed that, and then she came and had some time here. A lot of people felt she was awfully grouchy, but she had a lot of responsibility, and she had fasciitis most of her life -- the pain in her hips, and so on. Things people really couldn't see behind -- what misery. She was responsible to see that the work was all done. Responsible that everybody put their pencil back in the same place, that you signed in every day, and you signed out every day. She went beyond in making sure that the rules of Dr. Lloyd were followed to the nth degree, and she was honored with O.J. Snyder medal, and so was Dr. Lloyd. I think that the people around realized that she was the worker behind the scenes. He was the knowledgeable educator, so to speak. Dr. Swift, a recipient of the O.J. Snyder Award, was the one to see that the department worked, and she was great in mammography, too. She did all the mammography until she retired -- interpreted them. Dr. Lloyd was before her. Then she did it. Then other people moved in. She was the type that she didn't even let the technicians do the films. She would do them. So Dr. Swift

was the Vice Chairman of the Department. She was very excellent in helping radiology in any way that she could. She would have social times at her place at different times, and invite the other department members there, and so on. Yes, I think she needs recognition as a great teacher in her own way, and helper in advancement of radiology. The current faculty -- Dr. Helak has been with me for a long time. I believe ten years plus. He's been Vice Chairman during that time. Great diagnostic radiologist. Someone you could always depend on. I'm sure his number of misinterpretations over the years has to be far less than what the average is. Dr. Tilley, who was President of PCOM, was my Vice Chairman for many years. The staff respected him and would go to him with interpretations that they were feeling unsatisfied with anybody else. So he was very knowledgeable, and understandable. The other person that had played a role in recent years, Dr. Olga Treveloise, our current mammography specialist. She's an M.D. As I told you previously, we were always in need of radiologists, and could not get people here for the department. Either the College would not give us the money, or they would not give us enough to entice people in. She was an immigrant from Russia, and went to Cook County Medical School after she came to America, after her education in Russia, and repeated the residency program because of American standards. She came to the Department, and today she is the major mammography person, and is well respected in that area. I think I owe her a

lot of gratitude to get involved with that area and developing it. I think as a Chairman, you really love it when a person will get involved and want to make an area succeed. So I think those are the major people that we've gone over.

CBP: Just a few reflective questions here. If you were preparing a time capsule to preserve the memory of PCOM, what events of the last twenty-five years would you highlight for that time capsule? Looking back from about 1973 or 1974, onward.

RM: I think things that I would highlight that PCOM was accepted by the medical community and the HSA to have a CT scanner. I think the fact that we were allowed to become in the same medical group as the other medical school hospitals -- and the fact that those hospitals -- even Temple -- sent us a few patients, but we got patients from all over the city, whereas I can remember back in the early 1960s when professors from Jefferson were told they were not allowed to even come on our campus or teach our students, and that we were sort of outcasts. So during those same years of the 1960s and 1970s, we were starting to get recognitions where previously we didn't. And so to both have approval to move -- in our hospital, to have the 4EMV linear accelerator, and the CT scanner, were very much highlights of the radiology. Are you speaking mostly of radiology?

CBP: I'm thinking more in general terms now, as a college, as an entity. Not just

radiology. What you would outline if you had to pick certain events as being most important.

RM: Well, I think the most important event was the approval of D.O.s to be in the military service, which was a change in the acceptance of our osteopathic profession. I think the movement of the College to City Avenue Campus had to be a very big highlight. I think the selling of the hospital and Dr. Finkelstein's recognition of what is needed to make us survive --

[end of side two, tape one]

CBP: We're talking about the highlights of the last twenty-five years.

RM: I think one of the big highlights was Dr. Finkelstein's involvement and recognition that the College had to be more than just the students, but also had to be involved with post-doctoral education, and the College had to have a strong role in that area. I think without that, we would not be as strong today as we are. Because once you stop at the student level, and they go out and become alumnus, we lose a big thing as compared to the involvement of the post-doctoral in their part in the teaching program of the students. Whereas if that would have all been lost and gone out to other hospitals and schools, and so on, it wouldn't have tied us together nearly as strongly. And now this latest thing moving into where involvement with the other hospitals

and the coordination of education throughout the state and under the umbrella of the College. I think that's a very important thing.

CBP: What has been PCOM's greatest shortfalls?

RM: Money.

CBP: [laughs]

RM: It's tough to do much without having the means to make the money or gather the money, or to have the backing of groups. I think one of the problems was that we didn't have the money to have depth of faculty to let our hospital grow in the same levels like the University of Pennsylvania or Jefferson. So that when somebody said, "I have a brain tumor," you would think, "Oh, PCOM, because they have the greatest neuro-surgeon there," and so on. I think that goes throughout our profession, except maybe for a few hospitals, where we usually could not afford more staff and equipment than what our hospital would permit, and then the depth of faculty -- like the number of surgeons, the number of interns, the number of orthopedics, and so on -- was always at a level. We have one, but depth of faculty didn't allow the other people out there to know, "Hey, that's the place to go because this is what they have. Look who all they have there, what's going on." I think that's one of the shortcomings that because of the shortage of the money, the other big institutions had research and development that could move much faster than ours, and suddenly, with this super equipment -- high potentials, and so on --

we didn't have the money to compete. I think down at the basic level, fine.

But I think we moved into a Star Wars type of medical field out there, which we cannot afford to have, in depth.

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

RM: I think one of the major goals is to keep moving ahead, almost like the fact that you do not let the other things deter you from the fact that we're a good school, we have a lot to present to the public, give to them. We have shortfallings and so on, but also our continuancy and our dedication to preserve this type of medical education. A hundred years from now, who can say whether we will practice differently or the same. I think the future has to make us well-rounded physicians that can care for people in all areas. But we should be persistent in saying, "Yes, we can do that job," and we can continue with it.

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

RM: No.

CBP: Well, once you see the transcript, we can try and fill in some of those dates.

RM: Okay.

CBP: Thank you very much. This concludes the interview with Dr. Meals.

Index

American Osteopathic Association	23
American Osteopathic Board of Radiology.	4
Anatomy Department	13
dissection laboratory	12
Athletics	21
basketball	21
Football	22
rugby	22
Board of Radiology	23
bone boxes	11-13
Cathie, Angus	3, 13
Charity Ball	7
Christmas	8
Clinics	15
20th and Susquehanna	44
48th Street	13
College of Radiology	24
D.O.s	
military	48
Eaton, James Madison	4
Finkelstein	36, 48
Founder's Day	6
fraternities	
Atlas	9
Log	9
Phi Sigma Gamma	9, 10, 18
waning	11
Frosh Social	7
Gilligan, John J.	28, 30
Graduate Health Care Systems	36
Graduate System Hospital	41
Heilig, David	5
Hospital Service Administration	31
Hospitals	
48th Street	45
Lloyd, Paul Turner	3, 24, 26, 38, 39
American Cancer Association of Philadelphia	26
Sloan-Kettering Memorial Hospital	43

and students	27
Atomic Energy Commission	26
dept. of	23
O.J. Snyder award	45
publication	42
mammography	19, 46
Masterson, Eleanor	19
Meals, Robert	
Academic Chair of Undergraduate Radiology	36
Chair of Department of Radiology	34
medical equipment	
4EMV linear accelerator	47
CT scanner	30, 31, 47
MR	32
ultrasound	30
Military	48
Moeschlin, George	1
Nicholas, Nicholas	5
North Center Hospital	16
OMT	5
PCOM	
acceptance by medical community	47
highlights	47
shortfalls	49
Peffall, Hale	22
Popky	36
radiology	22, 33
cancer treatment	43
Children's Hospital Radiology Department	41
College of Radiology	24
dept. of	23, 26, 28
fellowships	23
Hobbs	23
Karibo	23
osteopathic vs. allopathic	41
research	42
residency	24, 34, 40
teaching	37
Rowland, Thomas	8, 30
Ruberg, Raymond	30
Sivitz, Dorothy	20

sorority	9
Squire, Lucy	39, 45
O.J. Snyder award	45
student housing	10, 11
student life	18
Students	
Women	19
Swift, Arline	44
training, outside	17, 18
Treveloise, Olga	46
Undergraduate Academy of Applied Osteopathy	20, 21
Union League	6
Union League	8
women	
World War II	20
World War II	20
Young, Galen	3, 4

End of Interview