

1997

Nicholas C. Pedano 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, "Nicholas C. Pedano Oral History" (1997). *Oral Histories*. Paper 19.
http://digitalcommons.pcom.edu/oral_histories/19

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 NICHOLAS C. PEDANO, D.O. (CLASS OF 1961)
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
May 6, 1997

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

PEDANO:

CBP: Could you please state your complete current
address?

NP:

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

NP: My desire to help people, and I felt that
osteopathic medicine was one of the truer forms of
holistic medicine.

CBP: What exposure had you had to osteopathy when you
were growing up?

NP: Interestingly enough, I was treated by an
osteopathic physician for a football injury many,
many years ago, and I felt that that was a dramatic
influence on me.

CBP: Was that osteopathic physician a PCOM graduate?

NP: Yes, he was.

CBP: Who was that?

NP: Dr. Marsiko.

CBP: Were any members of your family in the medical profession?

NP: No.

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

NP: Bachelor of Science in Biology from Villanova University, and I graduated in 1956.

CBP: Why did you select PCOM for your education?

NP: Well, I felt that it was probably the foremost college of osteopathic medicine at that time, and I was correct at assessing the real value of a college.

CBP: Had you even considered applying to allopathic medical schools?

NP: No.

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

professors, etc.

NP: Probably the most profound highlight was Dr. Angus Cathie, instilling a basic knowledge of anatomy, which I found served me further in many years to come in the practice of surgery.

CBP: Could you tell me a little bit more about Dr. Cathie?

NP: He was a very demanding and interesting individual who probably knew anatomy better than any individual I've ever met in my life before then or since then. He had a unique way of getting his thoughts across to the class, and was certainly an individual that was in the forefront of osteopathic medicine. One of the other things I rather enjoyed is Dr. Cathie treated me osteopathically when I was a student, and he probably gave me one of the best osteopathic treatments I've ever received.

CBP: Was there anybody else on the faculty at that time who you considered to be your mentor, specifically in the area of surgery?

NP: Yes, Dr. Galen Young. That dated back to my days as

a student, and then carried through as an intern and a resident of PCOM. I guess the other individual is Dr. Herman Kohn, who had influence on me.

CBP: Please share your recollections of working in the 48th Street Clinic as a medical student, including any anecdotes that stick in your mind.

NP: Well, it was a very interesting place, and Dr. Stiegler at that time, ran a very tight ship, as far as the students were concerned. We were given the opportunity to treat many patients and probably gave us an insight into family medicine that most institutions really didn't have because we were so-called "booth doctors" -- family physicians -- to many patients. I enjoyed that so much that I chose to intern at PCO, and I was only one of five interns at that time. I did my residency at PCO in general surgery. I was chief resident in PCO. I finished and became clinical instructor in surgery and went into practice with Dr. Herman Kohn for about a year-and-a-half.

CBP: Why did you choose surgery?

NP: Well, I always liked to work with my hands, and that was one of the very interesting things. I started in the first year in my residency -- I was in an orthopedic residency because that was my first love. But I liked general surgery so much that I decided to abandon orthopedic surgery and go into general surgery.

CBP: Do you remember any particular experiences that you had in the 48th Street clinic? Encounters with patients, with other students?

NP: Well, I think they were always appreciative patients, and at that time, certainly the role of physician, even though it was a student physician, was one that was highly regarded by the people that used that clinic.

CBP: Were there any typical cases that you were seeing there, more so than others?

NP: I don't believe so. I think it was a myriad of all types of cases.

CBP: During your years as a medical student at 48th Street, PCOM acquired the land and began to develop

its plans for the City Avenue campus. Please describe the conditions at 48th Street at that time.

NP: Well, while the building was architecturally sound, the accommodations for the students weren't the greatest. Probably the best thing was its proximity to the Hospital because you could walk across the corridor from the classroom right into the west wing. However, it certainly does not measure up to what the students have here today. The progress and the expansion to the City Line campus were really fantastic, as far as the students were concerned.

CBP: Did you have any expectation that the move to City Avenue might happen during your time as a student?

NP: Yes, it was delayed multiple times. However, as it was delayed, time was flying then, and I guess it was more of -- it became the story of the sign. The sign 'future home,' 'future home,' 'future home.' Then it took a set-back when the corner was sold off to WPBI during that time.

CBP: Why was that a set-back?

NP: Well, we had owned the entire land and we figured,

"Uh-oh. Here we go. Some of it is going to be fragmented now. Maybe they're going to decide to sell the rest of it," because it was valuable land and still is. So it certainly wasn't looked upon as a plus for the students at that time.

CBP: Although that sale, in fact, helped provide funds to build the College.

NP: Absolutely. But it was difficult to ascertain -- was the College ever going to really expand here?

CBP: In 1951, PCO acquired Women's Homeopathic Hospital in North Philadelphia, renaming it North Center Hospital. Please describe your experiences as a medical student, working in North Center Hospital.

NP: It was a very interesting institution in the inner city, and gave you an opportunity to see all types of medicine and surgery, and because of its location, I think I had an opportunity to see some of the things that you probably wouldn't see on a daily basis, unless you're in inner city.

CBP: Can you give some examples of what you saw there and what you would see --

NP: Stab wounds, gun shots, down to and including gun shots through our quarters at night. People knocking on the resident quarters, and intern quarters which were separated from the Hospital -- like a distance from here to Evans Hall. Unfortunately, it was a less-than-desirable neighborhood at that time, and it was not unusual to have your car broken into, or have a knock on the door and somebody standing at the door -- resident or intern quarters -- with a gun shot or a knife sticking in them. It was a real knife and gun club on Friday and Saturday nights. However, you got an opportunity to really practice some clinical medicine.

CBP: Was the resident and intern quarters an on-call room?

NP: Yes.

CBP: Or was that where you actually lived the whole time you were assigned there?

NP: When you were up there -- our residency was a little different than what my residents complain about

today. My residency consisted of thirty-six on and twelve off. The weekends began on Friday morning and ended on Monday night. Unfortunately, you were between both hospitals -- North Center and 48th Street -- and you were running back and forth. It was sometimes difficult because if you had emergencies going in both places, you had to be Ubiquitous so to speak, to be in both places at the same time. But we had very interesting and challenging residencies.

CBP: But you actually maintained a residence outside of these quarters?

NP: Oh, yes. Oh, yes. We had our own room. I had clothes there -- a change of clothes. Because, unfortunately, you never knew when you went in when you were going to leave.

CBP: Was the Salvation Army's Harbor Light Clinic at 8th and Vine open during your years as a medical student?

NP: Yes, it was.

CBP: Did you spend time there, either as a medical

student or an intern or resident?

NP: Interestingly enough, my time was more devoted to the clinics of 48th Street and North Center than Salvation Army. I was down at the Salvation Army on occasion, but not frequently.

CBP: What do you remember about that clinic at 8th and Vine?

NP: Once again, it was an inner city situation in which you really got an opportunity to practice family medicine on the inner city patients. Unfortunately, the better percentage of them were alcoholics and street people. However, they still needed care, and it gave you an opportunity to really practice with clinical medicine.

CBP: When you were a medical student, I understand that there were relatively few internships available upon graduation. Please comment upon the competition among your classmates.

NP: Well, now, I can't say that because we never filled the internship class here. I was one of five interns, and the intern class was not filled here.

Competition out of town might have been keener than it was in the Philadelphia area. Metropolitan *always had a tremendous amount of competition for* their slots down on 8th Street. But unfortunately, PCO did not share that at that time because it was looked at more as a work program than a learning program, and this is something we had to change. It was a service-oriented internship rather than a learning internship.

CBP: How was it turned into more of a teaching internship?

NP: Well, it was a combination of the younger guys that stayed and understood, but what they did not get and wanted to see the students and the interns and residents get, was the advent of a full-time teaching staff, which then gave them an opportunity to spend time here teaching the interns and residents. And certainly the surgical residency that I am Program Director of today bears no resemblance to the one that I did.

CBP: When would you mark the transition from a service

internship to an academic internship?

NP: Probably in the late 1980s or middle 1980s.

CBP: Up until that point, was the size of the internship program staying at around five interns?

NP: No, no. It was growing. It was growing. But then again, the class size was growing, so that was self limiting.

CBP: So quantitatively it changed sooner, but qualitatively it wasn't until the late 1980s?

NP: Yes. There were only sixty or seventy in my class. So if we got five out of seventy, as compared to getting twenty out of two hundred --

CBP: I'd like to talk to you a little bit about student life when you were a medical student. What were the highlights of your social experience at PCOM and in Philadelphia in the late 1950s and early 1960s?

NP: It was rather limited because I worked through school during my junior year in school, and between studying -- I guess the biggest thing was the fraternities at that time. However, as far as social life, that was sort of non-existent because

if you were working and going to school, you didn't have much time.

CBP: You were a member of the Atlas Club?

NP: Yes, I was.

CBP: Could you describe the rushing and initiation traditions of this fraternity?

NP: Oh, they were rather sedate compared to the other ones.

CBP: Compared to the other medical school fraternities or undergraduate?

NP: The other medical school fraternities, and certainly our rushes. Our so-called hazing period and whatnot, was negligible as far as I was concerned. Atlas was a very interesting combination of individuals. The ITS fraternity was known for gentiles, Log fraternity for the Jewish folks and the Atlas for the mixed blessing. There were Jewish and gentiles. And that's why I chose that. I did not want to only associate with one ethnic group.

CBP: What kind of activities went on at Atlas during your time there?

- NP: Oh, occasional dance, frat party, beer party.
Nothing really spectacular as far as real social
life, so to speak.
- CBP: Where was the house located?
- NP: Right on Spruce Street. I don't remember the
address.
- CBP: Did you live at the fraternity?
- NP: No. I was born and raised in South Philadelphia, so
I wasn't that far from school.
- CBP: So did you commute the whole time?
- NP: Yes.
- CBP: What did you do for recreation -- athletics?
- NP: Probably sports, when I got an opportunity. As I
said, that was rather limited because of your
working and studying. You didn't have very much
time.
- CBP: Were there any local hangouts, such as coffee shops?
- NP: Paul's and Dewey's, which was across the street,
which became our bane, so to speak, because when
you're an intern and resident at two or three
o'clock in the morning, it wasn't our guys over

there, but they were raising hell. It was hard really, if you were going to catch a couple hours of sleep. It certainly wasn't conducive to a quiet neighborhood at that time.

CBP: Where was this other place -- Paul's?

NP: Paul's was the delicatessen between 48th and 49th, on Spruce Street, on the south side of the street.

CBP: That was another place where students went?

NP: Yes. Well, most students -- if you could afford it -- you ran over to Dewey's and got something, or over to Paul's, or you brought your own lunch. Not like our cafeteria here.

CBP: I take it you were not married at any point during your PCOM years.

NP: No, I got married in my senior year.

CBP: Oh, okay. And then where did you live?

NP: South Broad Street, right across from St. Agnes Hospital. I was there for ten years.

CBP: Did you drive up to the campus, or take a little trolley?

NP: Drive.

CBP: What was the norm for students then, as far as being married or single?

NP: I think the predominant number, I suspect sixty percent of our class -- was single at graduation. Maybe forty-five percent. Somewhere in there.

CBP: Was there still a strong G.I. presence at PCOM during your student years?

NP: Oh, yes. And there were quite a few veterans in our class. There certainly was a sprinkling that I thought grew after that because the Vietnam War -- after I graduated, then I thought there was an increase in the number of vets that were here.

CBP: How about the presence of women when you were a medical student?

NP: We only had three women in our class, I believe. Or two women. Two women.

CBP: And that's a marked contrast to the way the College started out in the early years.

NP: Yes.

CBP: Why do you think there were so fewer women?

NP: I think that honestly it just wasn't that appealing

to women at that time. I think family values and raising a family and medicine didn't mix. And they still don't. You have to really make some sacrifices as a woman to decide if you're going into a profession and be gung-ho with the profession or you're going to raise a family. I have a daughter who's a physician who facing that right now.

CBP: During the 1920s, PCO students observed various traditions. For example, freshmen men wore dinks and freshmen women wore green ribbons in their hair. The Charity Ball, class dances and fraternal organizations were also part of the student culture for several decades. Can you think of any student traditions or activities that you would consider part of student culture in the late 1950s or early 1960s?

NP: None that sticks in my mind. We had the occasional dance, but I think that the regimentation of osteopathic life in the 1920s and 1930s and 1940s was more marked than in the 1950s and 1960s.

CBP: What kind of training had you received in surgery as

a medical student at PCOM?

NP: It was limited -- not like today's limited exposure, in which students have an opportunity to come into the OR with the video tapes and the different programs that we have available to them today. Observation -- if you got an opportunity to go into the old amphitheater, and whatever you could get on your own. If you knew a surgeon, you could go in and watch them. But it was rather limited.

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

NP: My internship was a rotating internship, which I thought was excellent. My surgical residency -- between the two hospitals, since there were only two surgical residents at that time, kept me busy, and I had an opportunity to scrub with multiple surgeons, and I consider myself lucky because I stole a little bit from each one of them. Dr. Kohn, Dr. Young, Dr. Young's brother, Abe Levin, Dr. Binder, Dr. Cort, Dr. Street. There was a multiplicity of surgeons, and I had an opportunity to scrub with them all.

Dr. Flack. I think you're really a compendium of what your trainers are. Hopefully you picked up all the good points and forget the bad ones.

CBP: Did you have any experience at Metropolitan Hospital?

NP: No, not until after I was finished.

CBP: How many years was your surgical residency?

NP: It was a three-year residency.

CBP: How many years is it now?

NP: Four.

CBP: Four years on top of the internship?

NP: Right. It was three years on top of the internship before.

CBP: You mentioned that you did a rotating internship.

NP: Yes.

CBP: How much of that rotating internship was devoted to surgery?

NP: Oh, six or eight weeks.

CBP: That's all?

NP: That's all.

CBP: But you were clearly on a surgical track at that

point?

NP: No. No, they didn't have tracks. It was not the same way that we have it now, where you can go on a medical track or a pediatric track. Be heavy in that particular field. You had to rotate through everything. Medicine, surgery, pediatrics, OB/GYN.

CBP: At that point, were you accepted into the residency program for surgery, or did you apply for that once you were in an internship?

NP: In my internship I applied for it.

CBP: Is that different today, though?

NP: No, no. They have to apply in their internships.

CBP: So they're not starting an internship program with a surgical track?

NP: No. They haven't developed the surgical track yet. They're close to it, but the ACOS -- that's one of the things that I have been sort of picketing. Not picketing, but requesting that the ACOS look into because I really feel that in four years, with all the subspecialty training that is necessary now, I do not have enough time to give these kids what I

want.

CBP: And the answer is not to tag on one more year of residency?

NP: Yes, because the government doesn't want it. They don't want to pay for that other year. That's the problem.

CBP: In the allopathic institutions, are the internships and residencies linked?

NP: No. They don't require an internship, so they can start right into it. Their PGY1 would be equal to first-year resident, which is our PGY2.

CBP: Okay. So their first year of residency is, in effect, the internship?

NP: Yes.

CBP: So they would apply once.

NP: Right.

CBP: Is that what you're trying to achieve?

NP: No. I think that we ought to maintain our rotating internship and just develop a track in that program. I think that they should have medicine, emergency room and pediatrics and OB/GYN because I feel that

makes them probably a better finished physician.

CBP: From 1980 to 1982, you served as Director of the Surgical Residents Training Program. Could you please clarify your leadership positions and their respective dates in PCOM's Department of Surgery?

NP: Well, at that time -- I think Dr. Street was -- it was between Dr. Street and Dr. Young. Because before I became Chairman of the Department of Surgery, I served under thirteen Chairmen of Surgery in this institution, which don't tell you very much about the longevity of the job. [laughs]

CBP: [laughs] No wonder I can't keep track of the hierarchy.

NP: Yes. I guess at that time it was the result that I was one of the younger guys, and I was very lucky and became a very busy young surgeon here. And as a result, had an opportunity to formulate what I felt was a very active program within the program. Even before I became Program Director. Because of that, I had certain things that I required of the residents on my service, and when they determined

that maybe this was good for the program, then they decided that I should be Program Director. [laughs] I suspect that what I did was really the progenitor of what was to come years later. I required a more organized program with a more structured setting, and I was very demanding of the residents. I felt surgery was a two-way street. If they wanted to learn how to do surgery, it was just as important for them to function on the floor as it was for them to function in the OR. I always maintained that I could probably take an untrained, unskilled person, and if he scrubbed with me long enough, I could teach him the technical skills of surgery. He may not know when to do it and why he's doing it, and I felt that the technical skills were only part of it. They had to have the other part. And besides that, I guess I was a stickler on their appearance and the way they treated patients because I felt that they had to be good people, too. And that's very difficult sometimes.

CBP: In the 1970s, did you run into the conflicts with

the long hair and all that?

NP: Oh, yes. And I was very resentful of it. I guess I was guilty of harassment because they'd walk in the OR and I'd say, "Are you scrubbing with me, Ma'am?" even though it was a male physician. And then I insisted that they wore a bonnet, much like a bee-keeper, to keep all their hair covered because that was something that I really never got into, and if you look at my hair today, that's about the length of it when I was practicing. I felt appearance was very important, and I felt that if you were sloppy looking, patients would get sloppy surgery.

CBP: Given your perspective and your years in academic medicine, could you describe the significant changes in surgical education at PCOM, both the undergraduate and graduate levels? I'm talking more about approaches to it, not just the number of years.

NP: Well, I think they had more clinical exposure, which was missing in the early years. They get this in a multiplicity of ways, not only as an undergraduate,

when they have an opportunity to come into the OR or view videos. With our telecommunications system, the surgeries can actually be viewed in the classrooms now. Either in class or in OR. Now you can do both. Number two is that I feel that we have really created a complex training program where we devote a good amount of time to each of the subspecialties, and insist that the resident become versed in these areas. I was never trained in endoscopy, except in rigid proctosigmoidoscopes. This was something that I went out and picked up the training myself. Colonoscopy, gastroscopies -- endoscopies in general is an important part of our surgical resident's training program today. Well, that was non-existent. Their rotations -- my affiliation with Sloan-Kettering for oncologic surgery, breast, G.I., lung, as well as their rotations at Cooper in pediatrics and trauma and clinical care, and DeBorja for cardio-vascular and thoracic surgery. That was non-existent. On top of that, they are schooled in the basic fundamentals of

surgical procedures on a one-to-one basis, and I feel that a structured program with integration and gradual steps is necessary to train the resident. You don't just throw them in and let them do a case. I had a hard time bringing about all the changes that I wanted. When I took over the program from Dr. Wisely, lord rest his soul, we had two residents. We now have sixteen residents. Each position is a funded physician that the College does not pay one penny for. So we've come a long way with it, but it's been a tough battle and it's been an ongoing battle which we've got to continually, continually upgrade. You can't sit on your laurels.

CBP: Currently, how many applications do you get for your residency spots, and how many do you accept?

NP: This past year I think we had eighteen or twenty, and I took four or five. It varies from year to year. It depends. One of the mitigating factors, of course -- and this is unfortunate because students coming out of an internship are sometimes swayed by what their paycheck is rather than their

training program. So because other places -- it's not that they have a better training program -- they pay more. They may have a less intense training program, which some of the interns prefer, rather than being worked, which is fine with me. I'd rather not have them in the program.

CBP: How was surgical education at PCOM impacted by the sale of the City Avenue Hospital to Graduate Health Systems?

NP: No effect whatsoever because my program is under the auspices of the College, whether that Hospital existed or didn't exist, doesn't really matter. It's only one of the rotations.

CBP: What percent of the rotation is there?

NP: I guess if you took the total four years, less than twenty percent.

CBP: Do you anticipate there to be any impact with the sale of the Hospital to Allegheny?

NP: According to Allegheny there isn't. But if there is, I am prepared to change the program as necessary.

CBP: Since that hospital became an allopathic institution in 1993, have you seen any prejudice towards your osteopathic surgical residents?

NP: Interestingly enough, no. I can't speak for the other residents, but you have to understand, the surgical resident is the locomotive from which the hospital is driven. If you have to take a choice between a surgical resident and a medical resident, and if you have an active ER, you want the surgical resident because he has technical skills. The emergency cases that need chest tubes or lines or whatnot -- a medical resident may not be versed in doing that. But even the first year surgical resident is.

CBP: Is there a very active emergency room here?

NP: Yes.

CBP: What further evolution do you envision for the surgical education program at PCOM with the 21st century approaching?

NP: Well, I think that minimal invasive surgery is probably an area that has only been scratched. I

did the first laparoscopic surgery in that institution back in the late 1980s. I think that this is an area that is going to become more and more organized and will probably lend itself to more same-day surgery than what you saw. The transition from when I was a resident through now on just simple cases. Gall bladders used to be in the house a week to ten days. Hernias, four or five days. Mastectomies, a week to ten days. Now, most of them are outpatients. So as you can see, there's been a full circle revolution or evolution in the thirty-six years since I graduated, and I suspect in the next thirty-six, it's going to be even more so.

CBP: Within the context of the osteopathic profession, please describe any ways in which PCOM's Department of Surgery has been at the forefront of its field.

NP: Well, I think that one of the things that we did that was somewhat bold and maybe not followed by some of our osteopathic institutions is that I insisted on these additional rotations in oncologic surgery, cardio-thoracic surgery, vascular surgery,

trauma, pediatrics, endoscopy. Now some of the institutions are starting to catch up with that.

But that was not the case.

CBP: So that's in the area of graduate medical education?

NP: Yes.

CBP: Are there any ways in either surgical practice, or even undergraduate education in the area of surgery that PCOM has been a leader?

NP: Well, this has filtered through the interns and the students because they're getting an opportunity to see things that were not present ten years ago. I mean, minimally invasive surgery, endoscopy. We have set rotations now for students as they come on service, to work through these areas.

CBP: What do you consider to be your personal outstanding achievement as an educator and practitioner?

NP: The creation of this program with the rotation and subspecialty training that was non-existent.

CBP: When did you take over graduate medical education for surgery?

NP: I think I became Chairman of the Division in 1988

and Chairman of the Department in 1989 or 1990. I have to look back. I don't remember. [laughs] As a matter of fact, don't you have one of my CVs?

CBP: I do.

NP: Okay. Well, you'll have to look on it! I don't remember. [laughs] Isn't that terrible? It feels like I've been doing it for forty years.

CBP: [laughs] Okay. Now I want to shift back to talking about the general history of PCOM -- the institutional history. In December of 1974, Thomas Rowland was inaugurated as PCOM's fourth President. Please comment on his strengths and weaknesses as a leader.

NP: Well, his probable strength was the creation of the full-time faculty, which was very necessary. His weakness was that he could not appreciate how to integrate the combination of these full-time people and the independent people without creating a polarity down the middle of the institution. Tom and I were very close friends until I refused to become a full-time surgeon. And once I was

classified as an independent, I was the rebel, which was fine with me because it didn't matter one way or the other. What he mistook is that along with me were multiple independent general practitioners. And as a result, I maintained a very busy surgical practice, in spite of the fact there were four, and at one time five, full-time surgeons. I was doing more surgery, volume-wise, than all of them together. And the reason being was because the independent general practitioners, who were not on salary with the institution -- I did all the work of the full-time guys -- John Angeloni and his group. So that unfortunately, I feel that if he was able to dissolve that polarity, it would have made a stronger institution quicker than it did.

CBP: Do you think it was a mistake to try to create a whole-time faculty here?

NP: No, but I think that while he created the whole-time faculty, he should have recognized the fact that there was a place for the independent practitioner, which he never did. If you weren't whole-time --

CBP: So did that cut-off teaching privileges?

NP: No, no. It modified them. However, I still -- my exposure was decreased, which was fine because I was busy at the time, and getting busier, and I really didn't have the time.

CBP: Were you paid for your teaching time?

NP: No.

CBP: Please describe the highlights of the Rowland years, from 1974 to 1984.

NP: Well, I think the purchase of this building that we're in right now and the creation of the full-time faculty were probably two of the highlights. It's very interesting, even through every day. There are people who either loved him or hated him.

CBP: You're not the first person to tell me that. It's consistent.

NP: And unfortunately, it's because of that reason. He was a nice guy. And interesting enough, I felt -- I guess -- a little insulted because if I chose to go as a full-time surgeon, I felt that he was my friend, and because I was not going along with the

program so to speak, I was suddenly -- which was okay.

CBP: During the Rowland years as President, Robert W. England, D.O. served as Dean from 1973 to 1984. Please comment on Dr. England's contributions to PCOM's educational mission.

NP: Well, I think that Bob really had a set agenda that he wanted to maximize osteopathic medicine, and I felt that that was good for the institution, but it had to be in correlation with the other clinical specialties as well. I think that sometimes he lost sight of the fact that medicine was important, surgery was important. For the most part, I think he did a good job. And maybe that was necessary to bring back osteopathic medicine as before.

CBP: Was he approachable by the students?

NP: Oh, yes. I say yes as a physician. I don't know if the students felt the same way. You'd have to speak to a student from that era. I know that he probably didn't share the personality as well as the esteem as Dan Wisely, God rest his soul. Dan was a unique

individual and was a very close friend of mine. We hit it off from the very beginning, despite the fact that he came in as Chairman of the Department of Surgery over me. I just respected the man and there was a chemistry between us, and I feel that PCO lost a strong supporter. He was a very interesting individual. He would say years ago, when a student had to see the Dean, the student was in trouble. Now when a student has to see the Dean, I'm in trouble. And he's right.

CBP: Yes.

NP: And I don't think any of the Deans ever shared that. Kenny's a great guy, with his degree and organization, but he doesn't really have that esteem and that love for his students.

CBP: From the students or for the students?

NP: From the students and for the students, like Dan did. I mean, Dan -- he would do things that are just -- you wouldn't believe some of them. If he thought a student would need something, he'd go out and buy groceries for them. He took a turn up at

Laporte, only to go up and be with the students and cook for them for the weekend. Christmastime -- he was always digging in his own pocket. He was just a unique individual.

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

NP: I was on that search committee and I think that J. Peter was probably the best of the candidates and had working knowledge of the institution at that time which the other people did not have. He was an honest individual, with good morale and integrity, and for that reason, became President. Unfortunately, he was not ready to affect the changes that were necessary with the institution and that led to his downfall. I feel that position has to be a very fluid position, depending on the needs of the time, and has to be predicated by the needs of the institution rather than by a set agenda by either the Board or the President. And multiple

changes that you see today is that you have a very fluid Chairman of the Board as well as President. You don't respond to what the necessities are.

CBP: Do you think, in retrospect, that Joe Dieterle would have been a good choice as President instead of as Dean?

NP: That's hard to say. It may have very well have been a good -- I think Joe would have been a good President. Would he have been better than Peter? I don't know. Because different men react differently when they get into that position.

CBP: Was he considered at the time?

NP: Oh, yes. Oh, yes.

CBP: What were some of the highlights and shortfalls of the Tilley years -- 1984 to 1987?

NP: Well, I think I mentioned the fact that he was a very intelligent individual and with his Quaker upbringing, was very honest. He had great morale integrity but would not change with the times to do what was necessary. And I think that especially in the area of full-time faculty, he was ruled more by

Herb Bolden than by what was necessary. And unfortunately, it caused both of them a lot of grief. Morale was very low -- the student morale, as well as the full-time faculty morale -- and I think it was time for a change.

CBP: Could you talk a little bit more about the role of Herb Bolton in all of this?

NP: Well, I really didn't have the opportunity to get to know him well. However, some of the things that I understood that were attributed to him, as far as the restraints for the full-time people and the financial status of the institution and what was occurring, they may have been poor choices on his part. I don't know.

CBP: Who brought him in?

NP: It was probably J.Sidney and the Board -- Dalck Feith.

CBP: Jay Sidney, meaning Judge Hoffman?

NP: Yes. That's who would have a say in that.

CBP: Could you be a little bit more specific about some of the challenges that Tilley faced in the mid-

1980s?

NP: Well, I think that there was a continual drain in the College by the poor occupancy rate of the Hospital, and the college was probably on the hook for seven or eight million a year to support the Hospital, and it couldn't be done.

CBP: Why was occupancy a problem at the Hospital at that time?

NP: Because of the PR of the institution. The combination of the polarity between the full-time and the independent individuals, and it had driven some independent practitioners out of the institution, and it created a slow but steady downturn in their census, and the Hospital was losing money. It could not be maintained on the individuals that were here, try as I might to put every case in here. It still wasn't sufficient to wash back the red ink. Something had to be done or we were going to lose both the College and the Hospital. That was a given.

CBP: In January of 1986, the Board approved

reorganization of OMCP or PCOM into five separate corporations -- Hospital, College, Clinical Associates, Diversified Services and Management Services. What was the goal of this corporate restructuring?

NP: To diversify the financial responsibility because I was on the Board at that time.

CBP: How did it relate to changes affecting hospital finances, such as DRGs?

NP: It unfortunately had very little effect upon the red ink that was. And while it might have been wise to reorganize and separate some of the things, it did not really effectively correct the problem the Hospital had. And that continued to drag on the College, financially.

CBP: In 1988, President Tilley and the Board of Trustees obtained a \$22.9 million bond issue to try to help the situation here. Could you please comment on that bond issue and whether it helped?

NP: No.

CBP: Did it cause subsequent problems?

NP: No, the bond issue and the restrictive covenants created more problems for the Hospital and the College because they had to operate under a set of rules and unfortunately -- I guess at the time that the bond issue was obtained, some of the covenants that were inserted there made it very, very difficult to exist under those covenants. And despite the bond issue, the red ink continued to wash. And I think that probably one of the things that added to it was the failure of the full-time faculty to carry its weight financially. And that I blame back to Dr. Rowland because when this was created, instead of instituting an incentive plan in it, so that the individuals were working like they would be in private practice, they were guaranteed their salary whether they saw five patients or fifteen patients. So, as a result, they saw five patients. As compared to an individual like myself who was independent, and if I saw five patients, I made x number of dollars. If I saw fifteen patients, I made 3x. If that was instituted at the

inception, I think the entire thing would still be going on. But that was never the case.

CBP: Okay.

NP: I don't know whether anybody ever identified that as one of the real problems, but there was a marked difference on some of these people that were in private practice, and suddenly full-time. The other rule in my office was if a physician or patient called and had to be seen, and I had twenty-six patients, I had twenty-seven patients that day. Not, "Sorry, Dr. Pedano's hours are over." You know, if I had to work until seven, eight, nine o'clock at night, it didn't matter. Some of the full-time men -- that was it. They would work two-to-four and then, "Bye." And that attitude -- that was a financial problem because they weren't generating income. But they were taking their salaries.

[end of side one]

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

NP: It was predicated upon the basis of the Orthopedic Department and Dr. Wynne, and unfortunately, Dr. Wynne was not of the ilk to be busy. Subsequently, both of them I felt were total failures because of his failure. I believed that Dr. Wynne was involved in a suit with the institution to recover some lost revenue or wages when he was dismissed. However, I think it was doomed from the beginning because the individual was in charge.

CBP: Does this go back at all to this concept of a full-time faculty?

NP: Absolutely. Same reason.

CBP: And not having the incentive?

NP: Same reason. John was a busy orthopedic surgeon up in New England. He came down here and sat on his

haunches.

CBP: Was he brought down from New England just to run this?

NP: No. The Department first, and then this developed. He was an excellent orthopedic surgeon. I mean, there was no question about his ability.

CBP: So this whole institute just failed and vanished?

NP: Yes. And actually -- I don't know what the final figure was, but I think that between the renovations and everything, it cost the institution over a million dollars.

CBP: This was also during the Tilley years?

NP: Yes. Another blow. [laughs]

CBP: Around 1990, Dr. Tilley began to suggest selling the Hospital. Please describe the different schools of thought about that proposal, and the factions it formed.

NP: Well, unfortunately -- and this included me -- I did not feel that the sale of the Hospital would aid osteopathic medicine in the city because Metropolitan was failing, and with the loss of this

institution, there is really no osteopathic institution in the boundaries of the city. It turned out to be a providential move because if we still owned this hospital, we'd be sitting out in "Never-Never Land" with all the different groups that are buying practices and hospitals, we would have little chance to survive. He was just ahead of his time. The difference was the sale of the Hospital was then predicated on the continuing of the clinical atmosphere for the interns and residents and students, and his thoughts about the sale of the Hospital and what eventually came to be were two different things. Unfortunately, I think he was ready to give it away just to get out from under it. A deal that was finally predicated -- the College made money on the Hospital -- and continues to -- and does not have the financial responsibility, but maintains the clinical atmosphere for the students, interns and residents. The factions that developed led to his downfall, and it's very interesting. Dr. Finkelstein, who later

became President, was adamantly against that at that time, but as the atmosphere of medical care in the city changed, and that's what I was talking about being fluid in that position. He changed this position.

CBP: Were the circumstances that different between 1990 and 1993?

NP: Yes. Worse. The monies were disappearing rapidly, and we were on the verge of bankruptcy.

CBP: Were you against the sale in 1990?

NP: Yes. And I was against it in 1993. I was wrong.

CBP: What was your feeling for being against it at the time, even though now you can say, in retrospect, you were wrong. What were your sentiments?

NP: I felt that we had to maintain an osteopathic identity in the city.

CBP: Even at the expense of pulling down the College financially?

NP: Well, I felt that the problem was in organization and the way it was structured. I probably was incorrect in assessing the fact that it could have

been restructured and come out as a financially sound organization because I wasn't blessed with the insight of what was going to occur in the city. Neither was anyone else, actually, at the time. It just so happened it was a very good choice.

CBP: And do you credit Dr. Finkelstein with that?

NP: Yes.

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

NP: Well, the polarity that existed before -- one of the things that made this even more so was the dissolution of the full-time faculty. And there were a lot of unhappy campers, and that polarity grew even more so. In the poor financial status that occurred in that period of time and what was occurring as far as actual financial position of the College and the Hospital, made it very easy for change. And in light of the fact that Judge Hoffman

and Dr. Tilley, I felt were too rigid in their thought process, and were not willing to change or to adapt to the changes that were occurring in the city at that time. That there was probably no other way, except for both of them to resign, and hire a new administration to come in and take over.

CBP: Could you comment a little bit more, please, about the changes going on in the city that you've referred to more than once?

NP: Well, I think that one of the things that led this institution down the path of destruction was the percentage of U.S. Health Care patients in the Hospital. And in spite of the fact that we had a healthy percentage of U.S. Health Care patients, the dollar amount that was appreciated was minuscule. Actually, the Hospital was losing money on the cases from U.S. Health Care. And as they gained a bigger share of health care in the city, it created more havoc in that institution. My own feeling is that managed care was probably -- or is probably -- the cause of multiple system failures in the surrounding

area. Not just this institution.

CBP: Because the hospitals can't afford to run on what they're allowing?

NP: Right. And unfortunately, while they have the patients now, so it's going to be interesting to see how the Allegheny system goes with it.

CBP: How can Allegheny deal with that?

NP: Create its own managed care system.

CBP: So they can control their own costs better?

NP: Yes. And once they control their cost as well as their institutions, it's easy. However, if you want my opinion, I do not feel that this is going to improve the status of medical care here.

CBP: How does that kind of approach fit in with academic medicine and furthering research missions and moving forward with patient care?

NP: Managed care does not contribute anything for post-graduate medical education. There's no pass-through. And certainly, if that is maintained in that fashion and is not mandated eventually by law to force them to do it, you're going to see those

graduate medical educations suffer a severe blow. And it's under attack right now because the government is cutting back what they're allowing. Third parties are not allowing pass-through, managed care is not allowing pass-through. All the hospitals used to get a fee for every intern and resident from the government Medicare and Medicaid that they had on salary. And now, as that percentage of patient is decreasing and the hospital's reimbursement is predicated on the percentage of Medicare and Medicaid patients as compared to HMO patients, you can see that that's going to be a severe problem.

CBP: But if that's the case, how would a place like Allegheny staff its own hospital?

NP: Two ways. Number one, by controlling the referrals from the physicians by buying the private practices, and number two, by controlling what the specialists can and can't do, and what they can earn.

CBP: But how are they going to have the manpower to do what the residents do in running hospitals?

NP: I don't know.

CBP: That's what I'm getting at. Where are they going to get their under-paid worker-bees?

NP: Right. That's going to be spelled out in the near future. And no one knows where that's going. I couldn't even hazard a guess. Now, they maintain that they want to sustain the integrity of the college and the teaching facilities and whatnot for interns, residents, students, etc. But if they're not going to be able to come up with any funds to continue it, it's going to be very difficult.

CBP: PCOM purchased the 214-bed Parkview Division of Metropolitan Hospital on July 10, 1990. What were the goals for graduate and post-graduate training for clinical practice?

NP: It was to enlarge the clinical exposure for the students to guarantee that they'd have areas for clinical exposure, as well as internships, residencies, etc. And also with the thought that the institution could make some money. Well, the primary came true, but the secondary did not.

CBP: Why was it a money loser?

NP: Well, I think it's a result of the socio-economic area that it's in. And if you've driven down Wyoming Avenue lately you'll see that this was once a thriving, blue-collar area. I don't know how long Parkview is going to continue to exist under the Allegheny system. What it did service -- it gave it more real estate to sell, and the College made out on the sale, but not on the management.

CBP: But the College also built a new building before they sold that one.

NP: Yes.

CBP: So did they still make out okay?

NP: Oh, yes. In spite of that. But it was based on a sale. Not on what they made from the hospital. Because their occupancy rate was between fifty and sixty percent, also. I don't know where it is right now, because I'm not privy to that. Off the top of my head, I would say that Parkview will not exist the way we know it today within two years.

CBP: Was there any goal for undergraduate medical

education at Parkview?

NP: No, just the expansion of the clinical activities for undergraduate medical education. But that was it.

CBP: Meaning another place where undergraduates could go to be in a clinic setting?

NP: Right.

CBP: We started to talk about this a little bit. I wanted to get back to the events leading up to the sale of the City Avenue Hospital to Graduate. There was sort of a turn-around in seeing that it was actually a good thing.

NP: Yes. And once the terms of the sale were decided, then there was no question that the College would come out of it financially more secure.

CBP: How did this sit with the alumni?

NP: Very poorly. And I think there's some of them that resent the fact that driving past, it's no longer a hospital. It's Philadelphia College of Osteopathic Medicine. You can see the Allegheny sign on it.

CBP: Do you think that the institution has been able to

make up lost ground with the alumni?

NP: Partly, but not all the way, and I can say that from personal experience and from Capital Campaign Chairman.

CBP: That's what I wanted to ask you. Since you're the head of the PCOM Mission, do people actually comment to you and say, "Since you sold it, I don't want to have anything to do with you?"

NP: Absolutely. And that's less and less because they understand the cliamte now -- what wasn't very clear then is becoming much more clear as each day goes past. [laughs] The question is, are enough of them going to find out before the end of the mission?
[laughs]

CBP: Yes.

NP: It's a race.

CBP: I'm curious about the PCOM mission. Is there any period of class years where you have the biggest drop-off in participation that might reflect your experiences or sentiments?

NP: You know, we haven't done it in that fashion, but it

would be interesting to do it. I'm certain Hale and Pam could do that for us -- find out.

CBP: I'm just wondering if people were disgruntled because they were here with the Tilley transition, or were they disgruntled way back in the 1960s, and that's what you're seeing.

NP: And some even from the Rowland days, and some date back to the Barth days. And certainly the PR is all together different. When I was a staff member, I remember over at 48th Street, I remember Tom Rowland addressing the medical staff of the Hospital at that time. "You guys don't like it here -- get out." Now, that's all well and good, but a lot of them did, and they took their work with them.

CBP: Did Barth say something similar to the alumni?

NP: Yes.

CBP: He was going to go build this place?

NP: Yes.

CBP: They could take it or leave it?

NP: Right. So, I mean, egotistical statures notwithstanding did not help. [laughs]

CBP: In your opinion, does Dr. Finkelstein have the right blend of communication with the constituencies and decision-making capabilities?

NP: My toeless gunslinger -- yes. [laughs] Because sometimes -- Len and I have been friends for many years. We shared an office for eighteen years over at 2 Bala. I guess if you can call us cohorts -- peers -- we're from the same vintage. He is now tapering what I considered his worst habit, and namely, before he thought what he was going to say, he'd say it. That's why I call him the toeless gunslinger. Before he gets his gun out of the holster, he shot his toes off. He's given me a couple of difficult chores at times because of that. Then I had to go back and recruit people to try and convince them if they want to give money or do something. But there's no question about his integrity. No question about his desire to make this a top-flight medical institution. And I think as he's been in the job, and I've seen the transition, like wine, starting to age and mellow in

the right direction. And there are not many people that can argue with him or tell him exactly what they think like I can, but that's based on our friendship. That was the way it was always, when we were residents.

CBP: If you were making a time capsule for PCOM, what events of the last twenty-five years would you highlight?

NP: This institution, the campus.

CBP: As far as this institution -- could you be a little more specific?

NP: Yes. The Hospital -- in 1968 -- it's going to be thirty years. So this came about in 1968 or 1969.

CBP: The last twenty-five years -- from about 1974 forward -- to 1999, when we'll have the centennial -
- what would be in the time capsule?

NP: The progress of osteopathic medicine in the City of Philadelphia and the importance of the upgrading of the education of our students and physicians. You know, years ago they had an inferiority complex, and that's why they hid their degree. I always told my

residents, "I'm sending you out, and when you meet the surgeon in one of these institutions that puts a scrub suit on -- both legs at the same time -- I'll go watch him." I said, "Until then, you'll find out that they do it the same way that we do."

CBP: [laughs]

NP: I guess if I had to highlight anything, it is the improvement in the education. Throughout. I mean, from the students, interns, residents. And then the improvement in the facility. And if we're successful in this capital campaign, it will be a campus everybody will be proud of. Not 'if.'

CBP: When.

NP: We will be successful.

CBP: Your capital campaign comes to term in 1999?

NP: On paper it does. However, I'm not willing to say that will be the end of it at that time. I'm still accepting five-year pledges now.

CBP: How far along are you in the campaign, as far as what your goals are? What is the goal?

NP: Twenty-five million.

CBP: How much do you have pledged?

NP: I guess if we take all the big pledges that we just got lately, we're close to ten million. But the interesting part -- and this is the thing that makes me hope eternally, I guess -- that ten million is from about four hundred alumni. There are sixty-six hundred alumni. Now, I grant you that you have to take the last five years and discount them so you can say fifty-six. And say that you're not going to get anything from maybe another few hundred. So you're down to five thousand alumni that we haven't got yet. That's why I think the twenty-five is doable.

CBP: If you don't reach that, what doesn't happen here?

NP: Actually, that hasn't been determined because most of it -- I guess what doesn't happen is the Foundation don't get to a hundred million like we wanted, as quick as it should.

CBP: But there's no capital projects that would be affected?

NP: I don't think so. But, as I said, it's an ongoing

situation. We're improving the educational aspect of the institution throughout all the phases, as well as the institution's physical appearance and the buildings. It's something that goes hand-in-hand, I feel. Because if you have the facility and you have the teachers, and the academic part of this is an important part of the campaign. And I guess that I should add that, too, because the academics would suffer if we don't make the goal, because we'd like to fund every major Chair.

CBP: What do you feel have been PCOM's most significant contribution to the profession?

NP: The improvement of osteopathic education across all phases. That we do not accept inferior situations to train the interns, the residents or the students. And it's that constant striving for excellence. Like the old Oakland Raiders commitment to excellence. No matter how good my surgical resident training program is, I want it better. And as long as everybody associated with the institution has that same wish, then we'll continue to improve.

CBP: What have been PCOM's greatest shortfalls?

NP: I guess not to have the endowment that, say, a Penn or a Jeff has. To be able to do things that we want. Not to have that endowment has also affected research and scientific exploration and papers here. And I guess that probably summarizes it, because that's the basis for where we're coming up short. And once we got the money part straightened out, I think the rest will come. You can't drive Cadillacs in all departments, but you can afford Cadillacs in all departments.

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

NP: To continue to train an osteopathically-oriented individual, who not only has a grasp of the osteopathic concept, but also can go out into today's marketplace and be an economically-sound practitioner. That's the challenge. Because the dollars for medical care are not going to be there. And the graduates of tomorrow are going to have less

-- even though their improvements and refinements -- diagnostics and everything else -- the cost of it -- everybody can't get an MRI and a CT scan. With the onset of the aging population, it's going to be more difficult because you're going to have older people alive for more years. And that challenge has to be met. How to be able to do more with less. When I say less -- not less in the way of diagnostics, but less in the way of medical care, cost-wise. They'll probably have -- and continue to have -- the finest care available. But at what cost? That's what we have to temper.

CBP: That concludes my prepared questions. Is there anything else you'd like to add to this interview that we didn't cover, that you feel is important in getting down this recent history of the College?

NP: Well, for being present for probably the first third of the centennial, and to see the changes in osteopathic education and osteopathic medicine -- if we can continue that evolution, revolution and progress, we certainly can be very proud of this

profession. I was that way when I first started. I was born and raised in an area that was thick with allopathic physicians, and I never hid my degree. The first convertible I bought -- I bought the biggest D.O. plate that you ever saw that went on the front of it. I always said that I was probably lucky to come along at the right time because I was in that evolution revolution, so to speak. To do what you really love to do for thirty-five years, and I made a great living and educated six children through college and graduate school, some of them. And see that after we walk out, we're going to leave something better than what we found, what more can you ask for?

CBP: I have one last question for you. PCOM has established urban outpatient clinics in most corners of Philadelphia, but it has not touched South Philadelphia. Could you give me some insight as to why PCOM stays out of South Philadelphia?

NP: Honestly? I think that it was just the fact that the urban practices in South Philadelphia were so

highly cultivated that they felt they did not have an opportunity to expand there. There were many areas in North Philadelphia and West Philadelphia -- they were barren, so to speak. With good primary care, they felt they could build practices. I don't know how easy that would be in South Philadelphia.

CBP: Do you think there is more of a prejudice towards osteopathic physicians in South Philadelphia?

NP: No. The predominance of family practice in South Philadelphia is osteopathic physicians. I worked my way through my residency doing house calls -- covering osteopathic and allopathic physicians, pretty much at that time. Our pay was spectacular. I got a hundred dollars a month as a first-year resident. A hundred and fifty the second year, and two hundred as third year. But I made twenty-five dollars extra a month the second and third year because I was chief resident. Well, at that time, we had three children. [laughs] It's very difficult to live at that time. But I don't regret one moment.

CBP: Thank you very much for participating in this
interview.

NP: You're welcome.

End of Interview

Index

alumni	53
Angeloni, John	32
Barth, Frederic	55
Bolden, Herb	37
"booth doctors"	4
Capital campaign	58
Cathie, Angus G.	3
Diagnostic Related Groups	40
Dieterle, Joseph	37
England, Robert W.	34
Faculty, full-time	31, 33, 39, 41, 43
Feith, Dalck	38
Finkelstein, Leonard H.	45, 47, 56
Hoffman, J. Sydney	38, 47
Hospitals and Clinics	
48th Street	4, 5
City Avenue	5, 27, 28, 39
City Avenue Hospital, sale of	27, 44, 53
Cooper	25
Debora	25
Harbor Light Clinic	9
Metropolitan	11, 19, 44
North Center Hospital	7
Parkview	51
Sloan-Kettering	25
South Philadelphia	63
Internships	10
Kohn, Herman	4
Managed care	48
Marsiko, Christopher	1
Musculo-Skeletal Institute	43
PCOM	
bond issue	40

change in administration	47
reorganization	39
PCOM Mission	54
Pedano, Nicholas	
qualifications	2, 4, 17, 22, 30
Rowland, Thomas	31, 33, 41, 55
Stiegler, Theodore	4
Student Life	12, 17
athletics	14
Dewey's	14
fraternities	12
marriage	15
Paul's	14
Students	
veterans	16
women	16
Surgery	
Department of	29
education	24, 28
internship	19
residency	19, 26
training	17
Tilley, J. Peter	36, 37, 40, 44, 47
Veit, Kenneth	35
Wisely, Daniel	34, 35
Wynne, J. Brendan	43
Young, Galen S., Sr.	3