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Ida C. Schmidt Oral History

Philadelphia College of Osteopathic Medicine

INTERVIEW WITH IDA C. SCHMIDT, D.O. (CLASS OF 1935)
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
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PERLOFF: Dr. Schmidt, could you please date your full name, date of birth and the place where you were raised?

SCHMIDT:

CBP: Were you raised in Philadelphia?

ICS:

CBP: Please give me the address where you current reside.

ICS:

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

ICS: Well, that's a very easy question. I was run over with an automobile when I was five years of age, and I had two fractured vertebrae and I was hospitalized for four months in Presbyterian Hospital. They kept me from being a hunchback. They kept me in traction, and I healed well. But afterwards I had an acute sciatic problem. I'd wake up in the night screaming with pain. And they couldn't do anything for me at Presbyterian Hospital. Osteopathy hadn't been thought about at that time for me. But I did

become a patient of Dr. William Nichols in Frankford, and he realigned me and corrected it, and very gradually, he got rid of the pain. Well, he became my family doctor all through school and high school, and finally, when it came to deciding what my profession would be, osteopathy was first in my mind. And I made up my mind then, and I changed my courses to chemistry, physics and biology and Latin in high school, and from that time on, never thought of anything else. And here, after sixty years of practice, I'd do it all over again. I love this office, and I want to be here until I couldn't work any longer. [laughs]

CBP: Were any family members in the medical profession?

ICS: No.

CBP: Had you taken any college courses prior to matriculating at PCOM?

ICS: Well, no. But in those days -- this was before 1931 -- you could take college exams that the state gave. And if you could pass their college work, you could enter the osteopathic college then, with the college

credits behind you. So I did in chemistry, physics and biology. That's how I managed. After that, though, you had to have two years of college, and then three, and then finally four pre-med. So that's the way it is today. But in my time, if you could pass the exam, they didn't care how you got the information -- just so you could pass your exam. [laughs] Nervous time for me at that time.

CBP: How old were you when you started PCO?

ICS: I had lost two years of school when I was five because of the accident, so I was nineteen when I started in the Osteopathic, instead of the usual seventeen at graduation.

CBP: Why did you select PCOM for your education?

ICS: Well, of course, it's been the largest. But it's also very convenient to my home, being only a half an hour away. So that's why.

CBP: What were the highlights of your educational experience at PCOM in the 1930s? For example, courses or professors?

ICS: Well, we had a great deal of osteopathy and a great

deal of anatomy and neuro-anatomy. In fact, the professors that I had then are considered highlights -- their portraits are in our library because these were fine wonderful men in building up osteopathy, which had started in 1898 in Philadelphia. It had developed so nicely after that that all the hospitals were starting to recognize the fact that if you were educated at Philadelphia College of Osteopathy, you had a good student. The doctors at Abington and the various hospitals around very soon found out that they made good interns and residents. So they took them on, and that was a good example. My internship was in Lancaster, and I had no problem. I was there two years and was very well educated at Philadelphia.

CBP: Were there any particular courses, do you recall, as a PCO student, that stick in your mind as being exceptional?

ICS: Yes, especially the anatomy courses.

CBP: Who was teaching you at that time?

ICS: Dr. Green. He has long since gone, but he was a

wonderful teacher. And then we had, of course, neuro-anatomy. We also had a blind physician who taught us practical -- and his fingers, blind as he was, could pick out the lesions instantly.

CBP: Do you recall his name?

ICS: Yes. He was married to Marion Dick, who was a physio-therapist. A very good one, too. Well, it's left me. But he was a very fine -- I'll think of it before we go much farther.

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

ICS: That's right.

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

ICS: Yes. We had clinics in those days.

CBP: Where were the clinics?

ICS: Right in the hospital. 48th and Spruce. My work was directly right there. We saw the patients as we came in. We did histories, physicals. We had all

the specialties in that wing in the hospital, and it worked out very well. Dr. C. Haddon Soden was the osteopathic technician, and he got us very closely ready right in the clinic. We would do all the preliminary work, and then he would come in when it came to the osteopathic portion, and it was hands-on technique.

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

ICS: Yes, we had that. Especially in obstetrics. We connected with the clinic. We had the obstetrical patients, and the obstetrical staff would make sure that they were present. Even at the very last second before the delivery, they always seemed to manage to get there. We had that experience.

CBP: So would you go out to the patient's homes for these deliveries?

ICS: Yes, we did.

CBP: Would you be there on your own until the doctor would come?

ICS: That's right.

CBP: Did you ever have to deliver before the doctor got there?

ICS: Several times, but the doctors were right on top of us. The patients really suffered no problems. In fact, we had no problems at that time. When I interned in Lancaster later, of course, we had a situation in a private hospital in Lancaster. We assisted in surgery, and we took care of all the patients that came in from the surrounding countryside. So it was very good experience, under Dr. Ralph Baker. He was President of the AOA during my time there. He was a very fine surgeon. We learned a lot from him.

CBP: Where in Philadelphia were you going to do the home deliveries? What parts of the City?

ICS: It would have been in West Philadelphia because the college was at 48th and Spruce. It was very convenient. I was a lucky one to have a car in those days, and that's covered many a territory. I was known for that Franklin. Everybody knew my

Franklin.

CBP: What year car was it?

ICS: Oh, it would have gone back about to 1927. [laughs] We have pictures of it.

CBP: Please describe the specific training you received in osteopathic manipulative therapy while you were a medical student including the didactic and hands-on instruction.

ICS: Well, we had, of course, our clinics, and all of our patients were treated osteopathically. Dr. Soden was, of course, the chief technician, and we had classes under him, as well as using the osteopathic techniques in the clinic itself. We did a great deal of treating of each other. I'm teaching there now for the last twenty-one years. Every so often my students challenge me. They say, "Dr. Schmidt, I don't think what you've shown us to take care of an upper respiratory is going to work at all." I would say, "You pick out a student this week that's getting a cold and tell me what happened after you do what I've told you." And the next week they'll

come back and they'll say, "Dr. Schmidt, I was the one that was getting a cold, and my roommate did what you told us, and what do you think? I didn't get the cold. I aborted it. If I never believed in osteopathy, I do now." Well, this is what we went through then, and I'm going through it now, in teaching.

CBP: At what point did you shift from treating each other to actually trying the OMT on patients?

ICS: The end of the second year -- the sophomore year. They wouldn't let us touch the patients in the early didactic years. But when we started the clinics, then we were expected to give osteopathy.

CBP: That was at the end of the second year or the end of the junior year?

ICS: I guess you're right. It must have been the junior year. It seemed as if it was the end of the second. We were down in the clinic, but mostly observing the various specialties. Now we consider twenty-two specialties. Gynecology and gastroenterology and cardiovascular, and the students spend a month with

each one of these their junior and senior year. And it was probably like that then, although it seemed like we spent a good deal of our time in the clinic. We knew that clinic inside out. [laughs]

CBP: After graduating from PCOM, you served an internship and residency at Baker Osteopathic Hospital in Lancaster, Pennsylvania. Please describe that program and any specialized training you received while there.

ICS: Dr. Baker was a very fine surgeon and diagnostician, and, of course, we lived right in the hospital. Every one of his patients was given osteopathic treatments at least twice a day, and as many times as four times a day. We had a clinic associated with the college and the hospital, too, so we spent several nights -- evenings a week -- there. And, of course, we assisted Dr. Baker in all surgery, too. When he was not in the hospital and the patients were brought in -- emergencies and such -- we would handle that until he arrived. He lived only a mile away, so he wasn't too slow in getting there. The

patients would come in, and it would be history, physical, x-ray, lab work. Everything was done before he arrived. It was placed on his desk, and we stood in the background while he went over the patients. They got the best of attention. There was no question about that.

CBP: How long was your residency?

ICS: Two years.

CBP: Did you get time off?

ICS: Well, residents worked it among themselves. If you had Christmas, I had New Year's. We would work it like that. I lived right there -- right in the hospital. We had our quarters. We ate there and we went down to the clinic from there. We spent a hundred percent of our time there.

CBP: Seven days a week?

ICS: Yes. You have one weekend off, I have the next one off. That's the way it was. Nobody fussed. They were all very glad to work under Baker because he was a very fine surgeon, and with the experiences that you got in his hospital, there was no question.

instruments were arranged just so. And here it is sixty years later, same way. I only have to reach. I don't have to look. [laughs]

CBP: In looking back to the day you started your internship at Baker Osteopathic Hospital, in what way or ways could your education at PCOM have better prepared you?

ICS: I don't know how I could have been better prepared. We had great surgeons in my time at PCOM. It was PCO in those days. Dr. E.G. Drew was one of the surgeons that took a special interest in me. He knew me when I was a little girl. As a matter of fact, he had operated on me when I was thirteen with an ear involvement that I suffered from that accident when I was five. So he knew me over the years, and he trained us very well. Baker himself was very selective when he selected an intern. I was very happy. He asked his patients, as a matter of fact, "I'm ready to take a new resident. Would you prefer a male or a female?" And he was very interested to see that the women wanted a woman. So

this was his first experience in having a woman intern. I was it, and it worked out fine. I was happy to be there.

CBP: How did the Depression impact your experience as a medical student?

ICS: Scarcely at all. We were in a Depression when I went in. In fact, we were in it from 1929, when I was in high school. And except for not having very much money to carry on normal activities, still, my mother never let me worry. "Never buy a second-hand book. They're out of date soon enough. We'll squeeze and get the money for the latest editions." She was a German, and very positive. [laughs] A perfectionist, I might say. So it really didn't impact my experience, but it did a great many people. She scratched to get me through, but many people just couldn't go through. And several of my class had to stop a year or two and work, and then come back. And tuitions in those days were every low, in comparison, of course.

CBP: Do you remember what your tuition was?

ICS: Three hundred a year. [laughs] That wouldn't buy you a week now. But that's the way it was. And, of course, all the colleges were in the same category.

CBP: What were the highlights of your social experience at PCOM?

ICS: Well, we all got along very well. We had, of course, the charity balls. That was always the big affair. We had sometimes luncheons together, and different sororities and fraternities would meet together. I was in Kappa Psi Delta, and we often ate lunch together, and kept the friendship all through the years. But now it's a women's osteopathic group all together, and there's not that accumulation of luncheons and affairs until they go to the seminars, and then we have them. Coming up next week is the Pennsylvania Osteopathic, and a good many will be there. Several thousand. And, of course, I'll be there because this is one that's very convenient. It's right across the street from our hospital. These are the places where you see your friends from way back. Dr. Galen Young was a

classmate of mine. He's one of the famous people out there now.

CBP: I spoke with him last week.

ICS: Oh, did you?

CBP: Yes.

ICS: Wonderful man.

CBP: Yes. Where did the students live and eat when you were a medical student?

ICS: We didn't have a typical lunch room, as they have now, of course. Many of the students even brought their lunch, and if they were fraternity groups, they would often eat at the fraternity house. We did that with our own sorority.

CBP: Did you live in your sorority?

ICS: No, I lived at home. It was only a half an hour away. You studied better alone. At the end of each year when we were having our finals, I would bring some of my classmates up to the house, and we'd have bull sessions, and we'd really get ready for those exams. And we could do it better outside. There was very little interruption. My mother used to

chase us to bed finally at eleven. She'd say, "Now, you have to be able to think tomorrow when you take the exam." [laughs] She was a good one.

CBP: What was the norm for where students lived if they were not from around there?

ICS: In apartments. We never had a dorm as such, but there were apartment houses all around 48th and Spruce.

CBP: Could you tell me a little bit more about your experiences in the sorority?

ICS: Yes. We really had a great time. And some of the good techniques that we learned were from the sorority. We'd invite people that were out in practice -- doctors that were out in practice -- and they'd come over for an evening, and we'd have bull sessions. And you wouldn't believe how you pick up this point and that point from the people that are doing it all the time. And some of my technique to this day comes from that.

CBP: Where was your sorority located?

ICS: Oh, we didn't have a sorority house. They do now in

certain of the colleges, but we didn't have it. We just gathered together at a dining room or at one of the other apartments. That's how it was. It was much simpler than today. Nevertheless, we had a lot of fun. We enjoyed it. And we made good friends.

CBP: Was there hazing for sororities, as there was for fraternities?

ICS: No, we had none. I don't think we did anything that would raise an eyebrow. I can't remember a single thing in our initiation. Not a single thing. It was done formally, of course. They had the week of rushing, and that was great. But no, no problems.

CBP: Were you married during your years at PCOM?

ICS: No. Soon after. I graduated in 1935, and I had the internships for the two years -- 1937 -- and I was married June 1, 1940.

CBP: What was the norm for students, as far as being married or not?

ICS: A certain proportion. Nothing like today, I'd suspect. But there were a good many that would be married at the end of the year. But now it's a

great many. I think there's forty-eight percent women in the class coming in. They must have five thousand applicants, and we only take two hundred and forty. So we like to think we have the cream of the crop. But it's about forty-eight percent -- I think I'm right about that -- in the number of women to the men. But in my time, there were ten women in the class of a hundred and twenty. So there it was.

CBP: Do you recall something called junior spree day?

ICS: I don't remember it in my four years there, but they do have them because every so often in the literature, I get certain notices of this. Now they have a golf recreation day. [laughs]

CBP: Other than sororities, were there any traditions or activities specifically for women?

ICS: Well, not really. I don't think there was any special distinction. No, not that I can recall.

CBP: Have you any recollection of the founding of the first Charity Ball in 1935?

ICS: Yes. That was a wonderful orchestra. I can't remember the name, but it was one of the main

orchestras. It was a very gala affair. It was broadcast, too. We were coming into knowing what it meant for the John Q. Public to know what osteopathy was. And when this hit radio -- not television -- radio, in those days -- we thought that was pretty special.

CBP: Was the music from the Ball carried over the radio?

ICS: Yes. The music and to announce that this was the first Osteopathic Charity Ball.

CBP: Do you remember the founding of the Musical Society in 1934?

ICS: Yes, because I was in that. We had several good performances. We had a quartet, too. And I remember the four fellows in that quartet to this day. They were great. That was one of the recreational activities. It's amazing how many doctors play musical instruments, which I didn't. But I did sing. We have a great picture of us. It filled the auditorium stage.

CBP: What was the nature of faculty-student relationship when you were a student in the 1930s?

ICS: There was a very great communication between the two. For instance, there was not a single professor who wouldn't be able to help you out. If you were starting to slide in a special subject, they would come right to the foreground and help you out. Go to the library with you, pick out certain references. Later we had a wonderful Dean who said, "Now, don't let yourself slide. We think you're the cream of the crop to start with. But if you let yourself slide, come to me right away."

CBP: Which Dean was this?

ICS: This was Dean England. Robert England. "Come to me right away and I will pull you along. I'll get you tutored, if necessary. I'll get you into the library and we'll have special books. Don't let it slide." That's the kind of relationship we had. No problem. I was very happy where I stood in the class, so nothing slid, let me tell you. [laughs] They were great days. I used to say, "I got a smile on my face from the minute I pulled up to that college, until I left it." I just loved that place.

CBP: Women comprised 12.5% of your graduating class. In your opinion, how were the female students of the 1930s treated by their male classmates and faculty? How were they accepted by the patient community?

ICS: I had no trouble. The students went along with us, too. We were so deep into the subjects themselves. It didn't matter -- male or female. But it is true, men didn't want to see a woman beat him in class. I went through that. But nevertheless, I had no trouble with them. We had good relationships, right straight through.

CBP: How about your treatment by the faculty?

ICS: No problem. No problem. There was only one example that they did seem to show preference to the men, and that was in the cardiovascular department, which I wanted to get into, but I wasn't able to make it. I went into two other associations. Pediatrics and arthritic. But I had really wanted to be in cardiovascular, and I remember saying to the professor, "Does a woman listen to a heart and hear different sounds than a man?" He said, "Well now,

doctor. We just have always had men in our department, so we're going to hold it to that." So I went promptly went to the Dean. I said, "I can't get into cardiovascular," and he would not allow an altercation, so he said, "I'll get you into two others." So he did. Both of which I've used all these years in practice, anyway. Pediatrics and arthritic. They wouldn't do that today.

CBP: When you say you were getting into cardiovascular or pediatrics --

ICS: They were societies. Anybody that was especially interested -- there's hosts of societies now. But you can get into -- and, of course, you have your faculty sponsor. And you also have people that are especially interested in that particular specialty. So that's the way it was. We had them then, too. And that was the only one I didn't really have trouble with, but I just didn't get in. If we had the Dean of today, and our President today, I would have gotten in. But in those days, that was the way it was. This was a medical society -- masculine.

CBP: What took place in these societies?

ICS: Well, we had our meetings. We all had to write a kind of thesis to get in in the first place. Some of these were published. It was general meetings. Specific meetings over the year, so that you knew. Students have rotation now, and they know that by the time they finish their twenty-two rotations -- if they're going to specialize, they know just about what they're going to do. Well, we didn't have quite that many, but we did have it in the clinic -- all the different departments -- and you tended to go to the ones that you were especially interested in. And so were these societies. Whether it was bacteriology or cardiovascular or pediatrics or gynecology or neurology. Each one of those had its own professors.

CBP: Going back to your training in the clinics, would that have been an entire day that you would spend in a clinic, or was it part of your curriculum?

ICS: Certain hours. We never spent the whole day. The patients would come in and be given appointments,

and it was usually in the late morning and early afternoon. That's how it would be.

CBP: The 1935 yearbook included photographs of three women faculty members: Sarah W. Rupp (Neuro Anatomy and Mental Hygiene), Ruth E. Tinley (Pediatrics).

ICS: Wonderful woman.

CBP: And Marion A. Dick (Therapeutics and Osteopathic Technique).

ICS: I remember the one whose husband was Dick Smith.

CBP: He was the blind one?

ICS: Yes. I told you I'd remember finally. [laughs] Very fine fellow.

CBP: Could you comment on these women and/or any others who were a part of your education at PCOM?

ICS: Yes. They were very dedicated. Ruth Tinley was known not only for her teaching pediatrics, but she had a fine pediatrics practice. She also took part in the clinics, too -- the pediatrics clinics. Marion Dick did a good deal of physio-therapy. And even though she did a great deal of physio-therapy, her husband, with his fingers, was an excellent

technician. When he made a correction, it stayed corrected. I was one of his patients for one five-minute period. And let me tell you, I had had a sacroiliac for weeks and weeks. I had lifted a heavy weight. I was a junior at the time. They entertained at their own office, a group of our sorority. He asked, "Does anybody have a particular lesion to correct?" I spoke right up. He had me on the table, and you could have heard it like a gun shot in the next room. And I don't think I've ever had a sacroiliac since that to equal that -- or anything like that. He corrected it well. And his ten fingers -- when he taught -- even when he danced on the dance floor, he never banged into anything. It was amazing. He had lost his sight during the war, so he had been a sighted person in his early life, and had wonderful stories to tell. But his wife worked right with him until his death. She's still living, I think. Pushing into her nineties now. Healthy girl. [laughs]

CBP: Do any other women faculty members come to mind?

ICS: Well, no. Those were the three women of that era. Now, Ruth -- in Neuro Anatomy, we had to follow the text pretty well, but she was on the staff. But Pediatrics was one that we were with all the time. When Tinley came into the room, you paid attention. Everything she said was a pearl that you used the rest of your life. Good teacher. Her portrait is on the library wall now.

CBP: In your opinion, which other PCOM women (past students and/or colleagues) warrant special recognition for their achievements?

ICS: Do you mean since then?

CBP: Yes.

ICS: Well, in the beginning, I was up in Lancaster for those two years. Then, when I was getting ready to practice down here, I didn't spend as much time with the college. I did spend some time with Mary Hough in Media because I used to do her proctology. That's what Dr. Baker meant when he said, "You'll be so glad you're able to do this." [laughs] She was a famous woman, too. Nettie Turner was very good in

general practice. She was invited to the sorority functions a great deal of the time. I can't really recall -- now, later, Katherine England taught also the same time I was teaching down there, and she was very good. She was assistant to the Dean.

CBP: What did she teach?

ICS: She taught Osteopathic Principles and Practice. Very good. Very good. I used to tell the students, "Pay attention when she lectures, because you'll remember. Whatever she has taught you'll use for the rest of your life." There were two other women. One was in lab, and one taught, I think, freshman physiology. But they were not under my activities, so I didn't get to know those. I think that would be about it. Dr. Mellott -- his wife was also on the staff there [Helen G. Mellott]. She died of cancer of the breast, which was a tragedy because she was pregnant for her last child, and would not give up that child to have surgery or visa versa, and delayed surgery until the baby was a year old. Too late. But she was a fine woman. She really

gave up her life for that daughter. And her daughter -- the older sister of the one that took the mother -- is still practicing, and I think she's in Jersey. She is a very fine person. She has marvelous stories to tell. I see her at almost all the conventions, too. I'll see her this coming week. Elizabeth. Betty. Betty Mellott. She's married now, but I don't know her married name. But she still practices, and tells fantastic stories.

CBP: At any point during your career in osteopathy have you sensed changes in the position of or attitudes toward women in the school and/or the profession?

ICS: No. I can honestly say, except for that one incident of not being taken into the cardiovascular society, nothing in my sixty years.

CBP: What about the decreasing enrollment of women after the second World War?

ICS: That's true. Dr. Katherine England is a good example of that -- was the only woman in her class. Of course, she's twenty years younger than I. If I graduated in 1935 she would have been the year of

1955. I don't know how that relationship would be, but she was the only one in her class. But she went through just the same anyway. That could have been tough in certain instances, but she had no trouble either. She went right through.

CBP: How did you feel as an alumna, having been part of a class where 12.5% were women, and that was the norm for quite a while, and then seeing one out of a hundred being female? How did you or other women feel about that?

ICS: I've never really had a discussion on that. Whether it was because of the activities in the war, or whether it was just circumstantial. We don't think it's circumstantial now that there's 48% women in the class. But the women are just as capable. They give just as good osteopathic treatment. They are just as durable. I had several up here in my office as preceptees. There was one woman I had treating something like ten in the morning, and I had nine for her to do in the afternoon, and she came in in the afternoon, and by the time she got to the end

she said, "I don't know how you do it." I said, "Because I've done nothing else for" -- at that time it was fifty-some years. But I said, "No problem. Absolutely no problem." She wondered if she shouldn't take up dermatology so she wouldn't be doing as much treating. [laughs] But she was able to carry on. The classes that I'm teaching now -- no problems. Absolutely no problems. I teach them how to work with their own body weight so that they're not -- I tell them that I don't want them tired out when they go home. I don't want their husbands to say, "She comes home and she wants to go straight to bed. She's exhausted." I said, "You're going to be raising a family, so you have to conserve your strength. You have to decide what is the wheat and what is the chaff. You cannot scrub a kitchen floor. You can spend that energy treating a patient. You pay for somebody to do your kitchen floor. And so they listen to this. But most of all, they watch me treat my body weight. I'm eighty-four, and Bonnie will tell you, the last one

of the day gets the same amount of attention as the first one of the day. It's just the way you maneuver and use your body weight. No problem. That's the way it is.

CBP: There was a time in the late '40s when admissions policies actually were not to encourage women.

ICS: Yes. I don't know whether that was characteristic of the administrators at that time, or not. To my knowledge, there's no reason for that. Either financially or otherwise. It is true that a man going out to work a year or so and then coming back to college may make more money than a woman going out for a year, and then helping to finance her college. But to my knowledge, the families seem to pull together, and the loans are there, and they go ahead just the same.

CBP: The reasoning that went with that policy to keep down the number of women, was that women were going to give back fewer hours to the practice or to the community service. Therefore, the education was essentially being wasted -- not being used the best

way -- if you gave it to a woman versus to a man.

ICS: It doesn't work, though, in many cases. My own is a good example. I'm here at seven in the morning and I leave here at seven in the night. And I have no problems with that. Most men don't want to work twelve hours a day. People say, "How many days do you do that?" Well, I'm in the office four days, and I teach one day. Three of those days are twelve hour days. The other one is from seven in the morning to one in the afternoon. And I take that Thursday afternoon off to go to the dentist or do things for me. But other than that, there's no problem. They get back full measure of their osteopathy. Because ninety-nine percent of my work -- maybe one hundred percent, we should say -- is osteopathic. I was talking to Walter today. He's our professor of the sophomores down there. Alex Nicholas, of course, is chairman of the department. They tell me that they're worrying about how many people are going to continue treating osteopathically. Oh, and the students have an

answer. "We can do three patients medically while you're doing one osteopathically. And we're paid for three, and you're paid for one." So economically, they'll point that out. But I tell them there's such great joy. Never mind the money, but there's great joy in being able to give a complete osteopathic treatment and make all the corrections that they're very carefully taught. If you'd see the care that those students get in the osteopathic principles and practice. First they have a lecture. Then they have a lecture in the beginning of the lab. Then they have a movie of the correction. Then he demonstrates on the podium -- on the platform. Then they go back to their tables. There are fifty tables just like that, in the lab, and they work together, and we circulate among them, and our hands are on top of their hands while they're learning. I could take you, who have never given an osteopathic treatment, right?

CBP: Right.

ICS: And by the time you went through all five of those

things, you'd be able to do a little osteopathy yourself. Now, you wouldn't know as much anatomy as they know, but you would know and get the feel of tissue. Of course you would. You can't have it reviewed five times over. And I give an exam every single day. Every time I teach, there's an exam given. Well, they're ready. Those students are ready. Because they know part of their mark is that exam. So they're not going to be unprepared. There's mostly 90s and 100s on those exams.

CBP: Based upon a review of your yearbook, your graduating class contained no African-Americans.

ICS: Yes. That was not a problem in those days. But let me tell you, in the years coming up, the students, I would have to say -- and I give them just the same attention -- there's no such thing as race in our OP&P lab. Really, this is maybe in 1980 and 1990 a problem. It certainly didn't seem to be a problem for us in 1935.

CBP: A problem in what sense?

ICS: In discriminating -- for instance, in selecting the

students. Of course, in those years, anybody that was able to produce their four years of pre-osteopathic or take their exam and pass it, were taken. We didn't have anything like the trouble. Now they're selected from five thousand applicants. But we have a certain group that's come in, and I think this year just as many or more than ever before are Negro -- male and female. And there's no distinction. They certainly get the same amount of training.

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

ICS: Well, it's just about one hundred percent osteopathic. I do a great deal of rectal work. But then, those patients are also treated osteopathically, too. And gynecological. Every female is bound to do a good deal of gynecology because the women feel more comfortable. There's no question about that. Most women really feel more comfortable. It's just been glorious. If I had my time to do it over, I'd be right back here.

CBP: Over time, would you say that you personally have used OMT more, less, or the same in treating your patients?

ICS: It's been a hundred percent since I first went into practice. People come to me for that. "You're known," they tell me, "for your sacroiliac and your cervical corrections." I said, "I hope I'm known for shoulder and elbow and knee, too." [laughs] But really, this is it. In that many years of practice, your patients get to know what you do. And that's what I do.

CBP: Are you treating a wide range of ailments?

ICS: Oh, yes.

CBP: Would you be treating diabetic patients or someone with the flu?

ICS: Yes. I'm board certified in both family practice and osteopathy. The Academy of Osteopathy, of

that covers those twenty-two -- in fact, it was thirty-six, but we were examined really on twenty-six -- it was specialties. So we do it all. Yes. Just as a family practitioner would do.

CBP: How would you characterize the trend in the use of OMT in the osteopathic profession in general?

ICS: I hate to admit it because you're so carefully trained, but we don't find the young doctors treating the way -- in my time -- in 1935 -- everybody treated. And then gradually, if they got to be in specialties such as anesthesiology, for instance -- or surgery -- they didn't do as much. But even so, Galen Young is a good example of this -- as a surgeon. His patients were always given osteopathic follow-up. And if any of his interns neglected, he himself would go to the bedside and treat. In fact, we have a movie of him raising the rib technique. I used to say, "Galen, you're pretty vigorous on those patients that you have just operated on. I'm glad it was you giving them that vigorous technique." [laughs]

CBP: Please describe how OMT currently is incorporated into medical student education and residency programs, and also how the preceptor system works.

ICS: Yes. Having been a preceptor for seven or eight times with different students for a month each. Of course, those students see, right from the very beginning of the day, that osteopathy is given right through. And also, the relationship of the areas of the spine that we are working with -- cervical, dorsal, thorasic, lumbar -- you will find that the patients themselves expect it and know it, and would be bitterly disappointed if I had a fractured wrist and couldn't do it, which I had twice, and I had to bring some of my young doctors up, and they would treat. But I was always here. The patient feels good when she sees her family doctor sitting at the desk, even though I couldn't do anything. As a matter of fact, one of them had a cervical lesion that the young doctor couldn't seem to correct, and so with my good left hand, I cradled the neck -- and this was in a cast from here to here -- I made my

hip carry it through the correction, and the patient corrected and said, "Did it hurt your wrist?" And I said, "No, but there's two pins in there and I wouldn't want to do this all day long." [laughs] See what I mean? The patients are used to the osteopathic and they get it here. And I hate to admit it, but this is not used as much as we'd like. It's coming back, though. I would say in the last even five years -- it takes a great deal of effort and training and exams to get into the Academy. In fact, there's over a hundred now in it. But that has dated from 1928. You'd be surprised how few they would take. Now, there's hundreds going in, it seems -- other organizations. But the Osteopathic Academy keeps this for -- they like to think -- the well-trained osteopathic manipulative training. And so they make it tough to get in. Your exam is tough. It seems to me it's several days -- writing a paper, for instance, for publication. But the main thing is the osteopathic technique. And most of these people -- I must say almost everybody

that's teaching in that osteopathic principles and practice, has had some experience with the Academy. Either they're a fellow or board-certified, or in that respect. I'm both, so it works out all right. But remember, I've had sixty years to get there. But anyway, my preceptees -- all of them -- know that they're going to see the patient, examine the patient, take the history. And if there's any medical or specialized situation like proctology or gynecology or nose or throat or obstetrics -- I don't deliver the babies, but we carry them right up to the time of delivery -- they know they're going to do that. They're going to get it in this office -- a complete family practice. I had an interesting experience with a medical family, and she was having her second baby, and I taught her husband how to use deep pressure in the lumbar when she went into labor because it would not interrupt the delivery, but it would quiet down those violent contractions. The baby was delivered at Abington, and so he went right along with the wife into the delivery room. The

obstetrician was now getting into position and he saw the young fellow doing this and he said, "What are you doing, fellow?" And the fellow, who happened to be a young lawyer said, "Well, my osteopathic physician said that if I use deep pressure in the lumbar spine it will relieve her and it won't interrupt the delivery." "Well, all right. Go ahead," he said. He delivered the baby without any problems, and now he turns to his nurse and to his assistant and said, "Why are we not teaching

take everything out of my office, the last thing would be that table.

CBP: Many allopathic physicians used to view osteopaths and osteopathy as quacks and quackery.

ICS: I know.

CBP: To what degree have these attitudes and antagonisms changed?

ICS: They've changed a great deal. Because, how many men -- and I treat quite a few medical physicians -- because they know that they can't get it at their own hospital or their own clinics -- they will say when they're relaxing enough to say it, "The osteopathic student has everything we have, plus their osteopathy. They have surgery and obstetrics and gynecology and upper respiratory and pulmonary. Everything that we do, plus osteopathy." So there it is. And that's true in my office. I had to laugh at one M.D. that I treated. My husband came to the door at the moment and he said, "Your wife is the first holistic physician around here. She handles it from every standpoint." [laughs] David

said, "Well, I'm not surprised. I was one of her patients before we were married, and I'm not surprised that you'd say that." [laughs]

[end of side one]

CBP: What do you see as the major shifts or trends in the curriculum at PCOM since the 1930s?

ICS: Well, I would have to say that they immediately updated in every one of the medical subjects. We like to think that our curriculum is practically identical to the Penn and Jefferson and Hahnemann and Lankenau. Well, now, it was always osteopathic first, in the early days. But even Andrew Taylor Still, who was an M.D. to start with -- all they knew at that time medically, which wasn't very much, when he started his college -- he also had surgery and obstetrics because he had been trained very well in that, too, of course. But then came the anatomy, and that is the greatest difference between the two. We spend a great deal of time in anatomy. He used

to always have bones in his pocket, and his fingers were always playing with those bones. He knew those vertebrae better than he knew his name. People came to him because he could produce results. A headache, for instance. He would work on the cervicals and use certain pressures, and he, himself had migraines, and he would be able to control it by putting deep pressure there. Patients would come to him from all around because he could produce results that -- a little bit of medication that they had in those days -- maybe less than fifteen well-known drugs -- was all that they had to work with. Now we have a pharmacopoeia of thousands and thousands, some of which work against each other. Not that we don't use them. We do. Almost every one of my patients will have experiences that they'd have to have certain medications and injections, just as the M.D.s do. But that's not the first and only thing they get in my office. They do get the osteopathy. And we work on a direct nerve supply. For instance, my daughter-in-law had a hysterectomy at Abington.

I called to see her and she was up and down the hallway. They got her out of bed pretty soon. But she was crying with flatuency -- the pain pressing up. I said, "Take your shoes off and get in bed," and she did. I used the deep pressure. Very simple. I could teach it to you in thirty seconds. And sure enough, she started to pass the gas and when I got home she said, "Never mind the bunch of flowers you brought me. It was your ten fingers I needed. I really felt the difference, and I haven't had any gas since." Now, wouldn't that be a nice easy thing for the M.D.s to follow through on? And they would do it if they had any direct knowledge of it. I mean, it's non-invasive, that's for sure. It's not going to be opposing any other drug that they were giving. The nurses said, "Of course you're going to have abdominal pain. You had an abdominal operation. You're not going to get through without gas." She did. She finally had to admit that yes, she did get rid of it. It was just an osteopathic principle. So I would have to say

that certain groups now are talking about manipulation. It's horrifying to me that they would even suggest giving the M.D.s a few courses -- maybe it would be a year or two's courses in osteopathy. Because they've already had the other. But we were very jealous of the osteopathic accomplishments over these many years. And we really didn't relish sharing them, but now I have a feeling in the future you will see the average young doctor will have a little bit of both. Maybe a great deal of both. It hasn't come up quite yet, but it's almost on the horizon now. Yes.

CBP: Has there been any shift in the PCOM curriculum, with either more or less emphasis on basic sciences, or more or less emphasis on clinical training or OMT, over the years?

ICS: Yes. I would have to say that in the basic sciences, they are keeping those right up. There's a standardizing reason for that. We all have to pass word exams, and the students are getting ready for that right this minute. At the end of their

sophomore year they'll be getting that. But they are right up-to-date on that. And, of course, I don't have to tell you, the osteopathic has been forcibly right up-to-date. We have probably more osteopathy in our Philadelphia College than almost any of the others. Pamona -- California Osteopathic -- specializes, especially in their cranial technique. They're very proud of their cranial technique. I was at a convention and I treated some of their students, and they were so surprised at our corrections, because they didn't do that. They had the cranial. They said, "Could we come east for a week and maybe pick up some of your corrections, because we don't have this?" I had to smile. I said, "Maybe I should go west and pick up some of your cranial." But we are doing a good deal of cranial now, too, in that same course, because every one of those students are taking exams that are composite of all seventeen colleges. So you get to know which is the specialist in this and this. And that's what they would do. We couldn't dare let our

students take those exams and take cranial technique exams and not be well trained in them. So they have enough hours that they get trained in the basics of that.

CBP: What was the Research Department under F.A. Long in the 1930s?

ICS: He was one of the early ones in this, and it was an interesting thing. We didn't really have the attention. There were several in the country. One of them was a woman, who did a good deal of research work. Now we have to document everything, just because I can give a treatment to help get rid of a cold, and I say you only have to treat them once or twice and the cold is gone. I have to document that now. And we're doing more and more of this. Angus Cathie -- in fact, in the papers I just gave you -- we give credit to him because he was one of the first in our college to spend a lot of time in research. He was a great anatomist, too. I swear he could draw with both hands on the blackboard. He knew his anatomy inside out. And anybody who

studied under Angus Cathie was a good anatomist all in his own right. In fact, we have a museum that he started. Incidentally, that paper on the fiftieth anniversary, is in the archives. But since they've been moving things around so much, you'd have a heck of a time finding it. [laughs] But it is in there. But anyway, I would have to say that there's more and more research. There are grants now given for research. If it's an apt question -- for instance, Drs. Alex Nicholas and David Heilig and Katherine England and a group did some research in physiology on dogs in our college, and they produced lesions, and they saw the upper thorasics. The first four thorasics are the cardiovascular structures that we stimulate. It's fascinating to see if you stimulate there, and you have a patient under a monitor, you can see how the heart will beat faster. Or you can inhibit it, and you'll see the heart slow down. It's quite interesting. The students are always hypnotized by that -- that their ten fingers can bring about these things. Well, they did quite an

item on that. And it seems such a simple little condition to produce a lesion and see the heart change, and normalize it, and get it back to normal again, as far as the pulse is concerned. But that was a grant that was given. Everything now, in today's world, is documentation. Not word of mouth. Not experiences. You can tell a thousand experiences that you know from your practice you can produce this and this. That isn't good enough. you have to do it scientifically.

CBP: Do you recall what Dr. Long was doing with the Research Department in the 1930s?

ICS: No, I really couldn't because he had his own room -- his own kind of office and research -- and I guess it would be osteopathic, too. But I don't know that he worked with animals. But now they do, of course. De Bias was one that was in that department, too. Very brilliant man. His son is a lawyer.

CBP: What do you see as PCOM's contributions to research?

ICS: Well, osteopathically, even the federal government recognizes that we do more than standard work --

better than standard work -- in the research. And the grants are sort of sizeable, too. You wouldn't expect the government would be willing to give such sums of money, but they have done that. That's not true of our college alone. That's true of Kirksville and Kansas City and California -- Dallas. They are really going into that. Federal-wise, as well as individual colleges.

CBP: Do you think that research should be part of PCOM's mission?

ICS: Oh, yes. In today's world we can't be embarrassed and say, "We know these facts happen in general practice." We have to be able to document them. And when you do do that -- in fact, even at yesterday's lecture, there was a documentation and positioning of the wrist. Now, you can make a correction of those eight little bones of the wrist -- of the carpus -- in a second. No problem. But the government wouldn't necessarily accept that as gospel. Now they have somebody that's actually going into the tendons, and they almost have a gooey

effect, and we have to make a deep, deep change in the angulation. They do this with measurements and MRIs and cat scans, and they actually prove their point. Well, so important was that little simple correction of the wrist, which I can do with a flip -- that wouldn't have been good enough. They have to do it by measurements and by MRIs. So that was included in the national exams that are going to be given to our students coming up in a couple weeks. It wasn't included last year because they haven't done it yet. Now it's important enough that they are documenting it.

CBP: Could you please describe the highlights and shortcomings of the following four administrations at PCOM? Barth, Rowland, Tilley and Finkelstein administrations -- one at a time, starting with Barth.

ICS: Well, he was the original builder. Barth was a clever businessman. A really good businessman. And he dedicated -- in fact, if anyone made a donation towards the business -- Evans Hall is a good

example, which he was in charge of -- he got the government to duplicate it. If somebody gave thirty-five thousand, the government gave thirty-five. He put up a beautiful building. He was very special. In fact, the hospital was named the Barth Pavilion in honor of him. A good deal of growth occurred then because at that time they moved over from 48th and Spruce -- the picture right behind you is a good example of that -- to the new place. And it was Barth's push. He did a great job.

CBP: Any shortcomings you can point out in Barth's time?

ICS: If there were, I didn't know about it. Osteopathy was -- well, I wouldn't say it was the golden age because I still don't think we're out of the golden age. But it was growing very fast at that time. Yes. Who was the next one?

CBP: Tom Rowland.

ICS: Everybody loved Tom Rowland. He was a good administrator. It's too bad he died of cancer of the lung because if he had another fifteen or so years, it would have been great. The hospital grew

and Evans Hall grew, and we acquired another building which is named for him -- the Rowland Building. And, of course, many of the classrooms are there. It was a great time. I had started to teach at that time. There are certain stormy times. California had a very stormy time because some of the osteopaths out there -- the government, too, seemed to favor medical hospitals, and they spent more money on that than they did on the osteopathic. But the osteopaths made a bad mistake of taking a certain amount of training -- very little extra training and more money -- and became M.D.s instead of D.O.s. Mistake. Oh, boy, is that a mistake. They couldn't wait to get back again into the fold within a very short time. And that was when Galen Young was President. Well, also, the government now -- they were pushing them for the hospitals, and now they would not put up a medical hospital unless they also put up an osteopathic hospital, almost in the same block. It was really quite an interesting time in history. I hated it, though. I hated to think

that in such an honored profession that there would be so much animosity. But for those years, Galen had his hands full. He had to be on his toes in California, brought them out of that ordeal. And then nationally, we all got stronger because of that. But California still blushes a little bit about that mistake. It really was a mistake. Hospitals and colleges go through periods of time that things are not -- they're following the lead of somebody that's made a mistake. That's what happened there. And they're powerful now. Not as powerful as Philadelphia, I might say, but they're doing very well. And then we had Tilley. And this was a changeover because Tilley took over the presidency because we were left high and dry with the death of Rowland. It was really a tough time for Tilley. I knew his father, who was a ten fingered osteopath, as I am. And I used to worry because they were putting up things. I worried about the money. I'd say, "We don't have enough money for this." He would say, "Oh, yes, Ida. My

son says that we can go ahead and improve this and this and this. We have state-of-the-art in cardiovascular and respiratory. I worried because there were so many big things being done. It was like nothing to the big things being done now, of course, under Finkelstein. He has the sight, I think, for the future that I still worry about. And, of course, when took the hospital over, that bothered me a little bit. It wouldn't have bothered me as much if they had said, "Graduate Osteopathic" or "Osteopathic Graduate." They didn't. It was "Graduate City Avenue." That hurt my feelings because that was my hospital right from the beginning, from back in 1931. You'll see on the name plate it started in 1928, but I knew it when I started college. Not that I was there in the beginning -- I was over at 48th and Spruce -- but we were starting to get this together. We had the mansion as the main office building, and then the hospital went up. I remember in those days the heating system was a million dollars that somebody

donated. You wouldn't put a powerful heating system in for a million now, but you did in those days. And each floor -- it was with great pride with each floor going up. So they were growing years, and we're in that now. Finkelstein is doing great thing with not only the college buildings -- that would be Evans Hall and Rowland -- but they're expanding the new handsome garage, for instance. I don't know how many parking lots are around there. But he's coordinating everything. He has a little sign, "Pardon our dust." And let me tell you, there's plenty of building and cobblestones going over. You pick your way in sometimes. But in another year or so it's going to be quite the thing. So you see, there's several years of building. Especially under Barth and especially under Finkelstein. But Rowland did a great deal in the development of the classes, and he was very special with the students. He was special with the professors. If somebody thought that they had to have some time off health-wise, as Katherine England needed at one time -- he was very

kind to her. It was a question of he encouraged her to get well so she could come back to teach. He handled it very nicely. He was a well-loved fellow. So I would have to say the curriculum developed very quickly under him, too. Not that we were ever behind in the curriculum. It's just that we know more now. That pharmacopoeia, that physician's reference, used to be a little book. Now it takes both hands to handle it. So has medicine grown. If you just consider the last fifty years of medicine, it's duplicated over and over in size. When I first went into practice, you didn't have to have many drugs and you could make a living. Now that book is three inches thick or more. [laughs] I can't begin to tell you how much has developed. I would say the last fifty years has developed more than medicine from the time of Hippocrates up to that time, in just that short period of time.

CBP: What are your recollections of the problems during the Tilley administration and the transition into the Finkelstein administration?

ICS: Well, that was another thing. Money was an important factor at that time, and we really hadn't paid for everything that we had, and it had to be paid for. There's no free lunches. So it was a problem then of -- you see, Tilley took over at a time when we were high and dry without a President. And we were for a year-and-a-half. So he stepped in and took over. There was a certain amount of a political surprise at that. Some of the doctors thought that should be voted upon. It wasn't a formal vote at that time.

CBP: Then how did he get the position?

ICS: Well, to say he just assumed it is about right. And nobody really opposed him -- a few did -- because they wanted to have the political sense of voting. And I think he did his best to carry on, but it was a great big change. You know, it's one thing. Like in politics, if you have your party behind you, it's easier. Well, he didn't have anybody behind him at that time, I think. A nice fellow. A loving guy. Kind with the patients. He did the best he could,

but it wasn't easy. With Finkelstein -- again, it was sort of offered. But I think they voted on him. It hasn't been easy sailing for him either, because they have high dreams. It isn't just status quo. The idea is to go ahead and leave a mark, and believe me, they're doing that. If you notice when you park yourself, it's jammed with cars. Remember, there's nine hundred students, most of which I swear have cars. They don't all, but most of them. And, of course, there's the people in the hospital, and their visitors, and the six hundred odd doctors on the staff, and it seems like they're all there at one time. It's something. They're making a mark. But it's a question of -- we're in the building stage now. If you would see the donations -- the book on donations -- a good many people in and around these parts are donating to that. The students will mutter among themselves that they're walking over cobblestones, but they are helping to build these new buildings. [laughs] They told me that. But I have a feeling that we'll see the

benefit of that. It's hard to see it from day-to-day until you start to see cobblestones and concrete under your feet. Then you know that things are going on. Because when I go down there to teach, I go directly to my lab and I don't see anything else for those hours that I'm there, until I leave again. Therefore, I'm not cognizant of all the things that are going on. You see the obvious with the garage going up, and the addition to Evans Hall. And, of course, there's many changes in Rowland Hall. So you can't miss what's going on. But it won't be as beautiful until that's finished. But even now, the carpets and the new paintings and the new hallways -- it's showing its effect.

CBP: What was the general reaction of the faculty to the sale of the City Avenue Hospital?

ICS: Well, from my angle it hurt me to see it go. We had had the hospital from the early days, and you could almost say from like 1898. From the very beginning -- modest -- glorified homes in the very beginning. There were four or five changes before they hit --

it was Spring Garden and certain individuals. We were very proud of that West Philadelphia. And now when we bought this, we were very proud of that. And now to see it go -- we didn't like it, really. But there was no question -- they had to do it. They had to get the bills paid. I would have felt better if they just kept the word 'Osteopathic' in it. Right across the driveway is the Osteopathic College, with all its glory. But it hurt my feelings to see the hospital go. And I'm only one of many of those -- six hundred and some odd.

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

ICS: Well, in the first place, we have a very honorable college. We had state-of-the-art in the hospital, and we like to think that it was <u>the</u> largest of all the osteopathic hospitals and colleges. That would be an enormous contribution, even to the neighborhood around there. That depends entirely on the clinics, as well as the hospital. So from a neighborhood standpoint -- but from a teaching

standpoint, it's hard for me to say that this is the most osteopathic teaching institution because all of them have a certain amount of teaching osteopathy. But we really spend time on it. We really are pretty proud of the osteopathic background that we have.

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

ICS: Well, it would be very nice to have turned out of the student body a powerful amount of osteopathic teaching and manipulating doctors. That would say, I would say, our first goal. And why we got away from it -- maybe the government had something to do with that because with Medicare coming into the picture, and people being paid by insurances. It almost seems to be to get them in and out fast. And that's why my students will tell me, "Dr. Schmidt, we can do three medically while you are doing one osteopathically." So that has to be corrected. And it can be easily corrected if osteopathy should be

considered a specialty just as truly as cardiovascular and pulmonary and gastroenterology and gynecology and endocrinology. All of those specialties. Osteopathy is still considered as a family doctor. And so you're going to get those rates. You're not going to necessarily be driving around in a Mercedes. So you see what I mean? A Mercedes is not important to me. I'm very happy to do my osteopathy. But I know that if I'm going to be doing three times the volume -- for instance, twenty is what I do in the course of a day. That's about it. Whereas I would do sixty a day if I were an M.D. And I'd be paid for sixty different patients almost the same level as a family doctor. But I spend a half an hour with each patient. As an M.D. I'd spend maybe seven minutes. So this would be the contribution to make. Of course, when you're talking to me, you're talking to someone who has done osteopathy from the word 'go.' And it's fascinating to see the result. There's an older doctor -- older than I am -- an M.D. -- they asked

her when she's going to retire because she's ninety-two, and she said, "When the patients stop coming in." Well, the same thing here. When the patients would not come in, that's when I'd stop. I have to laugh. They voted on me to be professor emeritus but Finkelstein won't give me that title until I retire, which I have no intentions of doing. So finally, at one of the weddings that we both attended, we were talking together and I said, "You know, they voted for me to be professor emeritus." He said, "I know. They voted unanimously for you to be. But we want you to continue teaching for a while." I said, "Well, will I get it posthumously then?" He said, "I assure you." [laughs] But I have no intentions of stopping. I have too much fun in here. You know, this is my life. My patients all know it, too. So that's the way it is.

End of Interview

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