INTERVIEW WITH LIEUTENANT GENERAL RONALD R. BLANCK, D.O.
(CLASS OF 1967)
by Carol Benenson Perloff for the
Philadelphia College of Osteopathic Medicine (PCOM)
January 25, 1997

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

BLANCK: Ronald R. Blanck. My middle name is actually Ray.

CBP: Where do you currently reside?

RB:

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

RB: My family physician for virtually all my life, as I
learned, was and is a D.O. He's no longer
practicing, but he had a powerful influence. And
through him, I learned to know other D.O.s, and I
spent a fair amount of time at Lancaster -- then
Osteopathic Hospital -- now the Community Hospital.
In fact, I interned there. So through all of that --
when I decided to go into medicine, which was, I
guess, late in my junior year in college -- possibly
even the summer, between my junior and senior year,
CBP: What was the name of this physician?
RB: Harold Finkel.

CBP: Was he a PCOM graduate?
RB: You bet. Yes. He brought me down here and I interviewed with Tom Rowland, and then started in -- let's see. I finished college in 1963, so I started in the fall of 1963.

CBP: Is this the only medical school that you applied to?
RB: This was it. [laughs]

CBP: What college education did you complete prior to matriculating at PCOM?
RB: Four years at Juniata College in Huntingdon, Pennsylvania, with a degree in biology. I actually started out as an engineering major, so I took a few biology courses my last year.

CBP: Were any members in your family involved in the medical profession?
RB: None. No. That's actually not quite true. Actually, I found out long after I had graduated from here that my great-grandfather on my father's side and his brother -- so it would have been my great-uncle, I guess -- were Jefferson graduates, and practiced in Lancaster County, though I had no knowledge of that when I grew up. I never knew them and we never talked about them.
CBP: What were the highlights of your educational experience at PCOM in the 1960s? For example, courses or professors that impressed you in particular?

RB: Oh, there has to be three that immediately come to mind. First is Angus Cathie in Anatomy. I'll bet you've heard his name before. [laughs]

CBP: That's how everybody answers that question, without a miss. [laughs]

RB: Oh, yes. Angus was something else. And then there was our professor of pathology, Morton Greenwald. In fact, we dedicated our yearbook to Morton Greenwald. Angus was brilliant. He could draw better than anybody I ever saw, but was -- and I mean no disrespect to his memory -- not nice. Sheer brilliant, and all of that kind of stuff. Greenwald was nice and just made pathology interesting. And I think for us, the amazing thing was that was the transition from the drudgery of memorizing the language of anatomy and physiology and biochemistry to the pathology -- the translation of that now, and how it applied to disease, and so it's the first thing that we had really gotten into that we all went to school for, and he just did it in such an elegant way that it was marvelous. The third
professor that I remember is Jerry Sharf, who was a
specialist in internal medicine -- I guess still is.
I think he practices in New Jersey now. Jerry
Scharf. He also was an influence, though we didn't
see him nearly as much because most of our
experiences were in the basic sciences. We had
clearly clinical lectures our third year, but the
first two years were the big ones.

CBP: During the second World War, PCOM -- or PCO as it
was called then -- accelerated the four-year
academic program into three years, introduced
courses about war medicine into the curriculum and
incorporated civil defense activities into the
responsibilities of the 48th Street Hospital. Were
there any ways in which the Vietnam War affected
your educational experience at PCOM in the mid-
1960s?

RB: No, not really. It hadn't gotten to that -- well,
let me back-up on that. You really asked me the
question did it affect the medical curriculum in any
way that I could, even looking back on it, tell at
the time, or now say that it did? There were no
special courses or emphasis on wounds or ballistics
or stuff like that. Although, I guess, our senior
year protest began mounting. There were not even
any of the particular social consequences that probably occurred in schools in some later years -- that is, in the late 1960s and early 1970s. D.O.s were allowed to join in 1966, so the Class of 1965 could join, or previous classes. First draftees were in 1967, so that was the Class of 1966, after they completed one year of internship. We were the second class to be drafted, so I completed my internship in 1968, was drafted. Actually, I volunteered for the draft, knowing that that was coming. I just signed up and did that. Though I sort of consider myself a draftee, literally that's not true. I guess twenty-plus of my class went in at about the same time. Many of us went through basic down at Fort Sam Houston together.

CBP: Twenty out of how many ended up in the Service?

RB: Well, we had a class of eighty-four.

CBP: That's a pretty high percent.

RB: Yes. But those were the days that every two weeks they would -- it was a four-and-a-half week training course. They would graduate a class of six hundred physicians down at Fort Sam, half of whom would go to Vietnam, or more.

CBP: You were among the last PCOM graduates to receive your clinical training at the 48th Street Hospital.
Please share your recollections of the facility and the neighborhood on the eve of the hospital’s move to City Avenue.

RB: Tom Santucci and I edited the yearbook, and one of the pictures in it was one of Tom and me standing, looking over the structure of the then under construction City Line facility -- both the school and the hospital. So we were looking forward to that with a great deal of enthusiasm, and probably the move was two years after we left. 48th Street was an old hospital, far too small for the size of the classes. Even the relatively small classes we had then. It probably had enough classroom in the traditional sense and laboratory space. Nowhere near enough clinical space. However, in those days, we did two full years of classroom, and then late in our second year, we started spending a little time -- a couple of hours a week -- in a downstairs clinic that was also too small. Many of us snuck down to the old Philadelphia General Hospital -- now gone -- and worked there in sort of a sneaky way because we weren't supposed to do that, either on the school's behalf or the hospital didn't want us either, but we did it anyway. We got to know some folks from Penn and Jeff, and spent time there. Our third year was
mostly classroom, as well. Certainly no longer the case, where the third and fourth year were almost all clinical. But we had clinical, microbiology endocrine courses -- all classroom stuff -- during that third year. And only towards the end of it did we transition into spending maybe half of our time in clinical work, both at the 48th and Spruce facility, and there was one downtown -- I can't remember where it was.

CBP: 20th and Susquehanna?

RB: Yes, that's the one. A clinic down there. Old, decrepid, not big enough. So again, we took advantage of going to Philadelphia General. We'd go out to Kennedy Hospital, and do histories and physicals for five bucks a pop. Work in the emergency room, and you'd never get away with it today, with QA, but I sutured, I set bones, I did stuff -- and nobody supervised me, or at least there wasn't very much supervision. But you could do that in those days.

CBP: What was the position of the administration at PCOM at this time about your going out into allopathic institutions?

RB: Well, Philadelphia General was allopathic, and they were opposed to it. Even Kennedy, which was an
osteopathic institution -- they were reasonably opposed to it. And it had to do with the control that they wanted to exert over the educational experience, which, I think, is a legitimate concern. The problem is we felt we weren't getting enough of what they were providing and controlling in the clinical sense. So virtually, everybody did some kind of an externship at other places.

CBP: Do you feel that PCOM was behind its sister medical schools in getting you clinical exposure?

RB: It depends on the school. Probably behind some, ahead of others. I don't know where it fit in all of that. The only thing that I would say is -- and I think it's largely true of medical education -- most schools, and certainly the osteopathic schools did not provide enough clinical exposure, and what they did provide was not structured very well. So the student was left really on his or her own to a great extent, to get that experience. And most of us being fairly aggressive, did something. We went out all over the place.

CBP: Do you feel that the move on to City Avenue accomplished that?

RB: Oh, I think so. Yes, sure. With the link then -- the right link with the hospital -- the building of
other links with Parkview, I think, and some of the other institutions -- where I interned at Lancaster, there were alliances and cooperative agreements made that they began to, I think, structure that clinical experience and provide it in a much more rational way.

CBP: So is it fair to say that by the early 1970s, when the College moved over to here, that they were focusing more on the expanding clinical opportunities?

RB: That's my opinion, though it's not based on a heck of a lot of fact. It's a lot of hearsay. But in talking with folks from the mid into the late 1970s, I'd say that's true. Yes.

CBP: Please describe the clinical training you received in the clinics at 48th Street and North Center Hospital.

RB: They would set up an appointment with the patient, who we would see, and do whatever history and physical was appropriate. We were usually expected to do a fairly comprehensive one, and then we would write up our findings, our diagnosis, and what we thought was appropriate, as far as further tests or treatment. Faculty would come in, check over our work, say yes or no, and we'd get into arguments
about whether Lisex, then a new drug, should be used, and so forth. And finally, the patient would get whatever was indicated, and out they'd go. Very disease-oriented. Of course, that was very typical in those days on health promotion or prevention, and so forth. Though I would say that that was talked about, I would bet more than in this school than in most allopathic schools, because that is sort of the osteopathic philosophy. So I think the school did a lot of education in that area, though it was less well practiced, and we still don't do it very well. But that's, again, a societal issue. We'd see, maybe, three patients an afternoon. Few patients. A lot of down time. Faculty was pretty supportive, and I still remember a few of them. I'd be hard-pressed to come up with their names. One was a crazy pediatrician. Caruso. There were a lot of really goofy people -- I mean neat people, but they were all crazy! [laughs] We had a lot of fun with it. Again, it was relative. You can't learn a lot on three patients. You really need to see a high volume and have different kinds of educational experiences. But I think virtually all of us got that through then augmenting our in-house clinical training with the out-of-house experiences.
CBP: How about at North Center Hospital -- at 20th and Susquehanna? Was the experience any different there?

RB: No, the same thing.

CBP: Were there any more opportunities?

RB: Not really. No, not really. And they did have some inpatient beds there. You just reminded me of that. I may have done one rotation there, but most of my inpatient rotations were done either at 48th Street or at -- again, too many students, not enough patients -- or at Lancaster, which I was an extern there, bona fide during two summers, and I did rotations there my senior year, as well.

CBP: I've been getting a sense from speaking to different alumni, that at different times, there was either more or less emphasis placed on OMT. Where did that fit in for you in the 1960s?

RB: I would say it was a time when there was less placed on it. Much less than there is now. Again, too, having looked at the curriculum and talked to some of the students. We were taught it. Dr. Nicholas did an excellent job, and of course, Cathie was big into it, as was Bob England. But it was not done in the routinized day-to-day way that it's now taught, I think. It did not permeate.
CBP: Why do you think it had slacked off then?

RB: Oh, I think there's ebbs and flows in that. I think osteopathic medicine is much more than OMT, though I think that's integral to it. And certainly, we got a good philosophic underpinning of osteopathy. That happened to be a time that there was interest by a few in OMT but not in the bulk of folks, and therefore, we didn't get that. I think then, that grew again probably in the late 1970s, certainly into the 1980s and today, where it is much more integral to everything.

CBP: During the 1960s, PCOM students obtained supplementary clinical experience in the Harbor Light Clinic of the Salvation Army and Embreeville State Hospital, a mental institution. Do you recall spending time at either or both of these facilities?

RB: Yes, I did do a rotation at Embreeville. Gee, I'm glad you reminded me of that. I completely forgot that. I did not at the Salvation Army clinic. Emeryville was a three or four week -- something like that. That was a pretty decent experience. Lots and lots of patients. So we got exposure to diagnosis. Not a lot of therapeutic experience. Some knowledge of pharmacology, psychofarm. I participated in a couple of counseling sessions.
That's about it.

CBP: Was there other psychiatric training that you got here, in Philadelphia, or was that it for psychiatric training?

RB: Pretty much it. That was part of some of the clinic patients we saw, and of course, we got lectures on it. Let's see. George Guest did neurology. Who did psychiatry? I can picture him, but I can't tell you. There were three or four quite good psychiatrists that taught. And when I say taught, almost always a classroom lecture.

CBP: Was psychiatry less the norm, as far as specializing for D.O.s?

RB: Psychiatry was emphasized, I thought. It goes back to what I was saying about the philosophy. The mental aspect of disease was quite well done and presented. That was part of heart disease, ulcers - you name it. That was always an area. The trilogy of mind, body and spirit was something that lots of people talked about.

CBP: Did you do any home deliveries while you were a medical student?

RB: I did no home deliveries. I did ten or twelve or fourteen in-hospital deliveries. Or at least participated in them. Now, I actually did some at
Lancaster. I don't think I actually did any here. I assisted. And then as an intern, I did a bunch at Lancaster.

CBP: Were there any other clinical opportunities that you had as a medical student, that I haven't touched on yet?

RB: No, not that I can think of.

CBP: During the 1960s, Sherwood Mercer was Dean of the College.

RB: Yes! Sure was.

CBP: I'd like you to share some of your recollections about him.

RB: I thought he was a nice man. Helpful, caring. He taught a course in the history of medicine and did that, but my sense was -- and I say this from a student perspective, so that may be about a hundred and eighty degrees off -- this place was run pretty firmly by two people. One was Fred Barth and the other was Tom Rowland. Sherwood Mercer may have had some input, but not much. Those two ran it. So I always thought Sherwood was -- as I say -- a nice man. Ineffectual isn't exactly the right word, either. That's not fair to him. I suspect he was quite good, but we didn't really sense a great degree of control or input that he exercised that
CBP: As a student here during that time, with two powerful leaders, did you feel as though the students had any voice in their own education?

RB: Oh, absolutely.

CBP: How was that voice communicated?

RB: Two ways. One, through the Class President. Ours was George Pierson. He was the President for all four years. Tom Rowland used to love to take ex-military people -- older folks in, and then through them -- I thought we really did have a say now. Not much changed, but we had a say. You could do something else. Tom was sort of a gruff guy, but you could sit down and talk to him. And if you really had something that you felt needed to be said, he'd listen. He might not act on it, but he'd listen. And if you didn't make sense, he'd throw you out of the office pretty quick. Barth was not that way. He was unapproachable, I thought. He used to be the President of Philadelphia College of Textile and Science -- something like that. So he came as an academic administrator, and probably was decent at raising money and overseeing things and doing the politics of it. Day-to-day operations were clearly Tom Rowland, with Marge Archer and
Jimmy Wolf.

CBP: Who were they?

RB: His secretary and his administrative assistant. Carol Fox was here then, too.

CBP: I'd like to talk to you a little bit more about your student experiences here, but not the academic experiences.

RB: Okay.

CBP: What were the highlights of your social experiences at PCOM and in Philadelphia in the 1960s?

RB: [laughs] Well, there wasn't a heck of a lot of socializing. Actually, that's not true. My first year I lived with the Lichman family on 48th and Spruce Street. She was a widow with two daughters, and not left particularly well-off, so she put up students, so I lived there my first year and got to know them pretty well. Mrs. Lichman died years ago. Cookie and Sherry are her daughters. I'd love to know where they are. Somebody said they knew and they'd get back to me, but they never have. So there was a lot of family stuff that went on, and we were sort of included, with a couple of classmates we formed a study group. Sam Pietrandrea, Sheldon Wagman and I studied together for every exam. We were very good together. We did that for three
years. Our fourth year there weren't really many exams. So that was a lot of the social life. Occasional movies. Cookie's friends -- female -- I dated a couple. You know, you go to the occasional party -- that kind of thing. But we studied. We really, really studied. Sophomore year about the same, though then Sam and I worked as night watchmen at the Hayes Home for Men on Belmont Avenue, just down the street here. Sometimes when I stay at the hotel, I run by there. With another classmate -- Bob Burgess -- we'd make rounds at night and all that kind of stuff. We got our room, board and a hundred dollars a month. It was wonderful. And then junior year, Sam and I lived and worked at a funeral home. Videon Funeral Home in Upper Darby. We picked up bodies at night, which was really a drag. But again, a hundred bucks a month and free room -- no board. That's when we learned that there was a nursing school near here -- near 48th Street. Misericordia Nursing School. It was a Catholic nursing school.

CBP: I'm not familiar with that.

RB: Well, it probably is no longer. But there was a Catholic hospital north of 48th and Spruce, and there was a nursing school. So anyway, we learned
to know a bunch of nurses. So we partied with them for two years. It almost seems innocent these days. Good grief. We mostly didn't date. We'd just go to the same parties and we knew them, and we had a great time. That was about the extent of the social life. Well, then, in our senior year, we lived with Marshall Sager -- in fact, with whom I'm staying tonight -- in an apartment on Pine Street. 30th and Pine. That's where Marshall had a gun stuck in his chest and it misfired so he wasn't killed. I went in the house. It was the same house that we lived in -- a duplex -- next door, where he had killed two people and wounded a couple others.

CBP: 30th and Pine?
RB: 31st or 32nd. I don't know.
CBP: That would be the Penn Campus.
RB: Oh, well, then it's up -- 33rd.
CBP: The 40s and west are where there are a lot of row houses -- 39th and West and Pine.
RB: Yes. It was on Pine, somewhere around there. Yes, just north of the Penn Campus.
CBP: How did you get around the city in those days?
RB: Bus.
CBP: Did you have a car?
RB: Well, I guess I did. I didn't my freshman year
because I could walk to the Lichman's house. I think Sam had a car. My sophomore year I did because we had to drive from the Hayes Home. Junior year, as well. Senior year, as well. But we bussed a lot of places. Go downtown to some of the restaurants there. There was a place that played opera all the time. There's a place in an alley -- it was an Irish pub -- that we used to go to a lot. Places on Walnut, a football place. A lot of places around the Penn Campus because it was so close. All of the students spent an enormous amount of time in Dewey's Restaurant across the street, drinking coffee and eating hamburgers. Boy, I haven't thought about that in a long time. [laughs]

CBP: [laughs] I understand you were a member of the Atlas Club.

RB: Yes.

CBP: And the OB/GYN Society.

RB: Was I really? I had forgotten that.

CBP: Well, I saw that in your yearbook.

RB: Well, that's probably so.

CBP: Could you describe the activities of these organizations during your years of membership?

RB: I sure can't in the OB/GYN Club. I didn't even remember that I was. So I wasn't probably very
active. The Atlas Club, however, was one of four fraternities. Hillel, Atlas -- I don't know what the other two were. They had houses right around 48th Street. So some of the folks lived there, and they'd have parties there. You'd get poker games or something like that. It was not as it is on some campuses -- a central focus of social activities at all.

CBP: How about educational activities in the fraternity? I know that was part of its purpose earlier on.

RB: Yes.

CBP: Was that still happening during your time?

RB: Yes. Mostly in Hillel. The rest of them, not so much, although occasionally they'd sponsor something or other. But not much.

CBP: In your opinion, why do you think the number and role of fraternities have waned over the years?

RB: They've outlived their usefulness. There are other areas that serve as focal points for what fraternities probably once did, both socially and educationally or for any other kind of purpose. I mean, you can't maintain a house anymore for what people are willing to pay for dues, giving tuition and everything. It's actually the same thing as why we don't have officers' clubs very much anymore.
Nobody goes. There's too many other things going on, or other places that people can go. And they prefer to do that. I mean, people see each other enough in school, so they don't want to socialize again within that kind of an organization. Now, with a few friends, sure. You go out for a beer or for dinner or something like that. I think another thing has happened. I'll bet eighty percent of my class were single. I'll bet sixty percent are married now. I don't know. I have no idea. But I bet it's that. The same with the Army. The Army used to be all single privates. They're all married now. That's why we have more beneficiaries, even though the numbers of active duty have gone down. There was a sorority, too, by the way, although they didn't have a house. Relatively few women at PCOM. There were only two in my class. But one who was Mary Jane Gelnett, I think, was in the class after me, is still in the Army. I still see her every once in a while.

My next question contradicts what you had said just before. When I was looking through the 1967 synopsis which you co-edited, I noticed several pages featuring family photographs, which gave me the impression that married with children was the
RB: No. I have to go back and look at the numbers, but my impression is most were single. We were an older class. D.O. schools tend to have older classes than M.D.s. So indeed there were those married, and some got married during school. But I still think that there were eighty percent -- maybe it was who knows what. But I still think that there were far more single students in those days than there are today, I would bet.

CBP: Other than Tom Rowland's basketball team, were there any organized athletics at PCOM during your years as a medical student?

RB: No, not that I can remember. I'm trying to think if we had any intramural football. I mean, we certainly didn't have rugby like they do now, or any of that kind of thing. I don't think there was very much like that that was organized.

CBP: How would you describe the nature of faculty/student relationships when you were a student in the 1960s?

RB: Fairly traditional, a bit stand-offish for the basic scientists. Clear delineation teacher/student, with a few folks really interested in biochemistry getting close to the biochemistry professor or all of that. But mostly we wanted to get through all
this and get into the clinical stuff. We had an excellent class notes system. People would be assigned to do it. We bought a mimeograph machine and we'd mimeograph the damn things, so everybody had the same notes. I mean, we really lived -- and this is a little bit off from the question -- by the slogan "cooperate and graduate." We really did that, and there was not the competitiveness that I think existed in undergraduate schools for people to get into medical school. We were here and we wanted to get through. Now, how does that get in with the faculty? We were sort of united in a way, often against the faculty more than working with them. At least that was my impression. Particularly in those basic science years. Once we were getting through them, we certainly developed relationships with the clinical faculty, with Morton Greenwald, as I mentioned. Most of us didn't like Angus Cathie and some of the other folks around there, though there were always a couple who we thought were nice to us and so we liked -- we respected, I think, most of them for their knowledge. There were a few folks who had been clinicians or were clinicians, and who were teaching basic science courses that we didn't think had a clue as to what they were teaching, and
we had little respect for them, though we were careful to keep that to ourselves, back to trying to graduate. Clinical years were much better because we really got to know and like and admire the Albert D'Alonzos, the Nick Nicholases, the Jerry Scharfs. There was a woman OB/GYN. I can't remember her name. She was super.

CBP: Anita Atkins?

RB: Yes, Anita Atkins. Yes. Exactly right. Just a bunch of people. George Guest. A dermatologist -- Cressman -- that we liked. And that's where good relationships led to good education.

CBP: Were there student/faculty activities outside of the college setting?

RB: No, not that I remember. If there were, I didn't go to them. [laughs]

CBP: Because in the past, there were recreational outings, back in the 1920s and 1930s, to encourage student/faculty relationships.

RB: Yes, I've read about that. I think that deteriorated. I think this place has had a history of bad faculty/student relationships, to include recent years, that I think current administration is working very hard on, in trying to build those bridges and include them. And I think folks like
Ken Veit are doing a great job. He's somebody that the students can relate to. We did with Tom. We did with Rowland in a funny way, but many of the rest of them.

Did grades matter when you were a medical student here?

You needed to pass.

You only needed to pass?

No, not really.

Did it affect your getting placements for internships and residencies?

I don't think so very much because there were probably in those days, I think, more intern positions generally than there were osteopathic graduates. Those were the days when there were still a lot of osteopathic hospitals. No longer the case. Now I would expect it would matter more.

Upon graduating from PCOM in 1967, I understand you completed an internship at Lancaster Osteopathic Hospital.

Yes.

And that in 1968 you were drafted, or as you said, volunteered to be drafted into military service as a medical officer, and sent to Vietnam.

Yes.
CBP: What were your career plans prior to being drafted?

RB: Well, I was looking at being an internist. I always wanted to do that, and had looked into some residencies in the East Coast, and even had talked with Dr. Yunninger, who was an internist at Lancaster about eventually joining him in practice. I did a lot of stuff with him as an intern because I was so bad at surgery. They said, "Why don't you do a lot of medicine," and I said, "Okay, I will."

CBP: Left-handed. That's a clear disadvantage. [laughs]

RB: [laughs] That's right. So I wanted to be an internist. I saw myself as a general internist at a place like Lancaster, settling down. Though I was looking forward to the military. I thought that would be neat, too. I wanted to see what was going on in Vietnam. I had absolutely zero military background. Nobody in my family has been in the Army. But I thought that would be okay.

CBP: What was it you wanted to see about Vietnam?

RB: What was going on.

CBP: Medically or militarily?

RB: Militarily I think more than medically. I knew what was going on medically. Foreign country, war. I mean, I've been raised with stories of World War II. What was this all about?
Being inducted into the Armed Services to practice medicine as an osteopathic physician was a milestone in the profession's struggles towards recognition and equality. How did you honestly feel about your military path at the time it was chosen for you?

Oh, very positive. I thought that would be a great two years, where I'd have some different experiences, certainly, and then I'd get out and pursue my plans.


Absolutely fascinating. I would even characterize it as exciting, and mostly fun. I wasn't under fire every day, or anything like that. The fire fights were no fun. The few I were in were very, very scary. But I could function during them, and that was an eye-opener. I quit smoking cigarettes because I made myself sick smoking so much during a series of mortar attacks one time, which I guess was a positive outcome to all of that. But I loved the battalion I was in. I liked the people. I learned about soldiers. I liked soldiers. I came to admire the professionalism of the soldiers, NCOs and officers with whom I dealt, many of whom I've
remained close with. I was in one of their weddings and all that stuff. So that's when I really found out that -- I knew I liked medicine. Now I found out I liked the military. I would have stayed and done an additional tour in Vietnam if -- I'm the only child -- was. My parents are both dead now. But it was very, very hard on my mother, so I didn't do that. I came back.

CBP: When you were in Vietnam, how were you received by the allopathic medical officers?

RB: They didn't care. They were glad that I was there. [laughs]

CBP: Did they even know you were a D.O.?

RB: No. They did in Basic. If they asked where I went to school and I told them, they'd say, "Oh." Who cared? We were sort of all in this together.

CBP: So you didn't feel any differential treatment?

RB: No. And certainly not in assignment, because they sort of chose us by lot. "Okay, you're going to the fifth field. You're going to the fifth and twenty-second artillery. You're going to the fifth infantry." Might as well as thrown darts.

CBP: To what extent were you utilizing OMT in treating patients in Vietnam?

RB: Occasionally. Not very much. If someone had the
kind of problem that I thought could be helped by that, I would use it. But it was not part of my day-to-day practice. I mean, basically healthy soldiers who I keep their shots up, and if they broke something, I'd fix it. And if they had a cold or whatever -- more often than not, it was a malady requiring penicillin. At least if they were back in base camp, because they'd go out and get gonnoreah which is epidemic. I got to do fascinating stuff. Go out and take care of a village that was filled with bubonic plague. Those with pneumonic and septicemic plague had mostly died. So we did all the stuff to get rid of the fleas and then the rats, and then inoculate the village. I saw a lot of fascinating things. I did some military resuscitative surgery, as I had learned to do. Not a whole lot, but enough. So I felt that I could deal with most things fairly comfortably by the time I left there.

CBP: Were there any policies about using your osteopathic skills or not using them? Nobody had a problem if you came out and started doing some manipulations?

RB: No. Every once in a while in subsequent years -- not then -- some hospital commander would call me and say, "What am I going to do? How do I
credential somebody to do OMT?" I said, "Well, number one, I don't know that you have to. If they have general medicine credentials, you don't listen to everything, and they're trained to that. Then you can do it." So we consciously avoided making a good deal of "You have to have a policy in place that specifically permits it," and we just have avoided -- occasionally a hospital commander would come in and say, "Well, you can't do it unless I give you permission," and so you deal with that. That's happened three or four times.

CBP: Did you run into any patients who obviously had never been to a D.O. before, and then they saw you and you're exposing them to OMT for the first time?

RB: Yes, a few. I can think of actually a couple of specific instances. And I've heard those stories a lot, actually by some folks who ended up attending osteopathic schools. That was their first exposure, by someone who used OMT.

CBP: So was it generally positive then?

RB: Oh, yes. Oh, sure. Oh, they loved it. Yes.

CBP: Other than OMT, what special skills or philosophies, if any, do you feel you brought to your service in Vietnam as an osteopathic physician?

RB: Oh, in the traditional sense, not very much. But I
suppose an approach to patients' holistic care. Emphasis on wellness, emphasis on mind, body, spirit. You just don't take care of the disease, but a patient who happens to have stuff that involves all of them. But that's been true not just in Vietnam, but I think in all of my practice, and something that I espouse as Surgeon General for our whole system. And I think allopathic medicine has largely come around to believing that, as well -- using alternate forms and all of that -- of therapy. So I had a good rotating internship, so I was comfortable with and with OB and with general medicine, and I could do at least enough surgery so I didn't totally embarrass myself. All of that worked very well, at the level that I was expected to perform.

What special skills do you feel you acquired because of your service in Vietnam?

[laughs] Well, knowledge of what soldiers go through, and a little bit of an appreciation for what war is all about to a civilian community, as well as to the community.

Obviously you came to like the military, and upon your return to the U.S., served a residency in internal medicine.
RB: Yes, I came back as a general medical officer, actually, first at Fort Myer, Virginia, and was there for eight months. And during that time, I saw a newspaper -- an Army Medical Corps Bulletin -- with an announcement. Because I had still planned to get out. I saw the announcement, though, of an opening at Walter Reed. Someone had dropped out, so I applied, talked to the graduate education folks. I said, "I'm a D.O. I assume I can still apply." They said, "Yes," after checking. I drove up to Walter Reed, walked in. Interviewed, was accepted, and then started my residency in September of 1970.

CBP: How long did you stay there for a residency?

RB: Three years.

CBP: Where did you go from there?

RB: I was chief resident there. I stayed there on staff for three years, and I didn't go anywhere. I eventually became the Assistant Chief of Medicine and Intern Director and a whole bunch of other things that's on my C.U. I then was selected after that as the first Dean of Students at the Military Medical School, when it opened in 1986. I continued my attending and patient care responsibilities at Walter Reed, but also then did the medical student stuff.
CBP: How did you get from this role in medical education into your overseas work?

RB: Well, after being the Dean of Students, I was promoted early to Lieutenant Colonel and then to Colonel, so I was very, very young. Actually, I was the youngest Colonel on active duty in the army.

CBP: How old were you?

RB: Thirty-six when I made Colonel. So I was eligible then to become a teaching chief. I had been the Assistant Chief of Medicine, and so one of the guys who had been at Walter Reed -- then the Commanding General at Brooke Army Medical Center, who himself had been the Chief of Medicine, recruited me down there as the Chief of Medicine. So I did that. And at that point, the kids were little, and we were eager to go to Europe, so I volunteered -- a bad thing to do in the Army, but I did -- to be the consultant in medicine to the 7th Medical Command in Germany. I was set to go, my wife was excited, and then the Surgeon General needed somebody to head the Assignments Branch of Career Development Medical Corps Branch, so they took me off the Germany assignment, and then I had the Career Activities Office -- the Assignments Branch -- for three years.

CBP: Where was that?
Back in Washington. Much to my wife's dismay, that's where she's from. We could see the world, and we're back in Washington! Got picked up for and went to War College Senior Service School in Carlisle, and then really wanted to go to Germany, so then had the command in Berlin and Frankfurt.

The command that you would have had prior to those two other assignments?

No, actually, it was a different job than I was going to go to, and I wasn't interested in that job anymore. As a War College graduate, I was certainly eager to have a command.

So what was the command that you went to in Germany?

Hospital at Berlin. Two years of that, and then I went and took the Medical Center in Frankfurt.

And from there?

Then I came back. So that was four years in Germany. Then I came back to D.O.D. in Health Affairs just for a few months because the expectation was that I'd be promoted to Brigadier. I was. And then the job that I was lined up for was to be the Chief of the Medical Corps and the head of Professional Services Director at Policymaking Group within the Surgeon General's Office. It had all the consultants, and stuff like that.
Was that back at Walter Reed at that point?

In the Surgeon General's Office in D.C., in Annex in the Pentagon. I was an Army Staff Officer then.

What is the timeframe you're referring to?

That was 1990 to 1992. Then, in 1992, I went back to Walter Reed and I got my second star as the commander of the Medical Center, and eventually, we regionalized, so I also became the Commander of the North Atlantic Region.

I'd like to talk to you about D.O.s and you and the Gulf War in 1991.

Okay.

Could you tie those together for me? The role that the D.O.s played. If you have any sense of how many were involved in that effort, and where your responsibilities fit in.

Well, my responsibilities for the Gulf War were to set policies for the mobilization and deployment of the medical forces with operations that had to do with retiring recalls, had to do with mobilization of the reserves, had to do with standards of physical fitness, and all of that kinds of stuff. Whenever you bring those kinds of forces together, they're also -- do you take people out of graduate medical education? How about teaching chiefs, and
all of that sort of thing. And so that's what I dealt with. And that was great fun. And sort of scary, too, because we feared and expected far more casualties than we had. So it was doing all of that. That's when Fred Humphrey, who is the Dean over in New Jersey, was on T.V. going through basic course. He was a new reservist and had never been through the basic course. [laughs] So they were showing all the folks that we were training.

CBP: Did that keep you stateside?

RB: Yes, I was stateside for that. Yes. Still in the Surgeon General's office. D.O.s. Reserves and active -- there were D.O.s. How many? I haven't a clue. We don't keep separate statistics of M.D.s or D.O.s, so I can tell you exactly how many medical corps physicians I have. Right now, today, it's four thousand five hundred and sixty-three. Tomorrow it will be four thousand five hundred and forty-two. I don't know. It's something around there. But I haven't a clue if they're an M.D. or a D.O., until I get their individual record and look at where they went to school. Then I can tell you. But medical corps is medical corps.

CBP: Okay. Well, somehow I've been getting some statistics from time to time from articles I've been
reading that said --

RB: Oh, I'm sure people have estimated or looked. The AOA keeps statistics which are horribly out-of-date. The school keeps statistics which are even worse. I mean, Fred Ammerman, for example, is on the list of somebody on active duty. He left, I think, in 1988. [laughs] No, he didn't. He left in 1990. In the military, near as I can tell, it's somewhere between fifteen and eighteen percent of the physicians are D.O.s. I know that because I've hand-counted them from time to time. I just don't know in the reserves. I have no idea.

CBP: You said fifteen to eighteen percent?

RB: Yes.

CBP: That's higher than I would have thought.

RB: Yes, it's higher than the proportion of D.O.s in the civilian. Yes.

CBP: Why do you think there would be a higher proportion in the military? What is it about the military that attracts D.O.s?

RB: D.O.s love to come in for the GME. We have great GME programs. We also tend to have high tuitions and so if we pay it, that's great. That's why we get so many students from Georgetown. They have high tuitions. We get very few students from the
land grant colleges. We have very high tuitions. I mean, you get a few that are West Pointers that are particularly motivated. But --

CBP: And then they owe the military one-for-one?

RB: Yes.

CBP: Not such a bad deal.

RB: No, it's a great deal. I mean, you have to like the military. If you're uncomfortable dressing funny and wearing your hair short, you're going to be awfully miserable for a few years. But if you get past that stuff, we have a freedom and a commitment to quality, is our bottom line, instead of the dollars. Not to say we're not resource-constrained, and don't have to do efficiencies. We do, but it's why I like it. It's why I like it.

CBP: I'd like to get back to talking about your career track. You finished in the Army Surgeon General's office, you worked with the mobilization of medical forces for the Gulf War, and then you got your second star, and the command of Walter Reed.

RB: Right.

CBP: What were your responsibilities as the Commander of Walter Reed?

RB: Well, to oversee the clinical, academic and research activities within that organization of -- oh, I
don't know. Let me see. Walter Reed has a budget of plus or minus two hundred million, about six thousand employees affiliated with the military medical school, and then later I did the whole region. Walter Reed is its own installation, too, so I had installation responsibilities, police, fire, Department of Public Works, engineering -- stuff like that. So it was great fun. I mean, I loved walking around and seeing patients. I don't practice anymore. I did until 1990. Even when I commanded Berlin and Frankfurt, both out-patient, I even did a little inpatient work. I would never do ICU work anymore. I used to run the ICU at Walter Reed, but now I don't even understand the I.V. poles. They talk to you. That's ridiculous. No, it's neat. But it's things like putting health promotion into place. We downsized inpatient beds, reduced lengths of stay, implemented telemedicine. Ambulatory surgery was already implemented -- increased it. Set-up a Gulf War health ward separately to evaluate those with illnesses potentially related to the Gulf. I think I cut six hundred jobs in that time, and I'm proud of that because one, I needed to do it. As our budget declined, the way we practice is different. Two, we
didn't do one RIF. Not one.

CBP: What do you mean?

RB: A RIF is reduction in force, where you involuntarily separate people. It was all done through VERA VESI. Vera is Voluntary Early Retirement, and VESI is Voluntary Early Separation Incentive. And, of course, through attrition, too. As people quit, we just didn't fill them, and then move some other people around. So we did that very creatively, and I was proud of that. Big into distance learning. Put into place filmless radiology, high-speed CT -- the electron beam CT. So a lot of dynamic research educational activities, a lot of cooperative team building with physicians, with nurses, with technicians working together as an integrated team, taking care of patients and doing it more efficiently and cost-effectively, by the way. A lot of step-down units instituted hospitality training. The goal was to have the hospital as friendly as the Ritz-Carlton. So I brought Ritz-Carlton in and I had them do a train the trainer course, and we started putting twenty people a day, five days a week -- so that's a hundred people a week -- through an eight-hour hospitality course. Marvelous stuff, and I've now mandated that for the whole
organization -- all seventy thousand people. I'll see if I can get them through it. Of course, that never ends. So that was the fun of all of that.

CBP: This doesn't sound like a forty-hour-a-week job.

RB: No. [laughs] No, it's not. It's not. It's even worse now.

CBP: In the fall of 1996, you were appointed Army Surgeon General. Please describe your responsibilities in this position.

RB: I wear two hats. One is the Surgeon General responsible to the Chief of Staff of the Army for training, equipping, supporting and sustaining medical forces -- both in peace and war -- that are structured to support combat operations. And all of the new missions short of combat operations -- peacekeeping in Bosnia. I'll visit our hospitals in Hungary and Bosnia next week. Peacekeeping and humanitarian assistance in Haiti. Disaster assistance for Hurricane Andrew, and all of those other kinds of operations. The potential, which we're not structured for, that we'll be called upon to provide the medical assistance necessary if there is chem/bio terrorist episodes in the States, as there have been in Japan. So I do all of that and deal with the downsizing. Our numbers are going
down. Resource constraints. The new missions that I've just sort of described, and at the same time, of course, the implementation of all of the managed care that we're getting into. So I do that from a policy standpoint. That is, I work with the Army and with Department of Defense Health Affairs in how we orchestrate all of that -- with the Navy and the Air Force, too. But essentially, it's for those of us in uniform to support the Army in whatever it does in furtherance of national policy. The second hat I wear is I command the Medical Command. Medical Command is our command and control structure that oversees -- is in charge of, if you will -- all of the day-to-day health care operations that we do in our fixed facilities and in our clinics and in our veterinary areas and dental areas and research labs, and all of the training that we do for our combat medics and lab technicians and x-ray technicians and so forth and so on. We have the biggest Army school. We put, I think, something like sixty or sixty-five thousand students through the school in San Antonio -- the AMEDD (Army Medical Department) Center and School. I command that. It's a three-star command. I have a two-star Deputy Surgeon General. I have a two-star separate
individual Deputy Medcom Commander and for the first half -- for the policy part of it as Surgeon General -- I oversee and generally command about thirty-five thousand enlisted and fifteen thousand officers. The officers are physicians, nurses, administrators, dieticians, physicians' assistants, psychologists, dentists and veterinarians. The enlisted are in all of the technical areas that you might imagine, and ultimately, the combat medic. The reason I command them is not only do I give them policies so they have to follow those, but also they work directly for me in the medical command. Because these are the ones who staff the Walter Reeds or the hospitals at Fort Polk, and if we called upon them to go to war, I have fifty-two deployable hospitals and untold numbers of special neuro-surgery teams and preventive medicine teams. Then we pull them out of the peacetime hospital system and back-fill them either from other hospitals within the system or from the Reserves. And then sometimes the Reserves would be activated and deploy to a Desert Shield/Storm or even to Bosnia, though mostly we've used the Reserves in backfill roles. I orchestrate all of that in those two roles. One as principal staff officer the other as a commander.
CBP: To whom do you report directly?

RB: Chief of Staff of the Army. I also sort of work for the Assistant Secretary of Defense for Health Affairs, Steve Joseph, because, since 1992, all of the medical department budgets come directly from Health Affairs. They don't go through the Army. The fear was that the Army would siphon off medical funds to buy more tanks, or the Navy would siphon off funds for whatever, and so they give it directly through the services, but it's for us. So although I don't work for him in a command and control sense -- I work for the Chief of Staff of the Army, since all my money comes from the Assistant Secretary, I'm very nice to him.

CBP: [laughs]

RB: And, in fact, his Deputy was a PCOM graduate, Sue Bailey, Class of 1977, who I hope will get a -- she was very big in the reelect the President campaign, so my hope is that she will have the Under Secretary of Defense job, which is not a medical job, though she's a psychiatrist. But if she does, she'll be the Assistant Secretary's boss. It will be sort of interesting.

[end of side one]
CBP: What do you see as being your next career move?
RB: [laughs] After this I would love to be a Dean or a President of a school.

CBP: Military or civilian?
RB: Oh, civilian. I'll retire from the Army after this. This is by law a four-year job, so assuming I don't get fired, I intend to retire at the end of my time, and then I'd go do something else.

CBP: Is there anything you could be doing further in the military if you didn't choose to retire?
RB: No. Nothing more. I mean, some in Congress have talked about me -- nominating me for the Assistant Secretary job or something like that, which is a civilian job. But I don't think I'd be interested. No, I'd rather go out and do something else.

CBP: Okay. [laughs] You might have answered this question in part before, but I want this clear for the record.

RB: Okay. [laughs] Of course, I'm not a surgeon.

CBP: At any point in your medical career in the military, have you seen any prejudicial treatment towards you or your osteopathic peers?
RB: Not towards me -- not once. Yes, I have towards my peers in one way. I suppose you could say it's prejudice. There was a time, up until probably the
mid-1980s, where because of fear that the Residency Review Committee and a couple of the surgical specialties would not accredit our education programs in those areas if D.O.s were allowed to be residents, that there was great difficulty in having well-qualified D.O.s accepted into those programs. The then-Assistant Secretary of Defense, Bud Mayer, came out very strongly with a policy that D.O.s would be accepted, assuming they were qualified and so forth, as did the Surgeons General. But there was still some reluctance on the part of Program Directors to do that. That was gradually -- even more than gradually -- overcome so that I'd have to say that to the best of my knowledge -- and I follow this stuff pretty closely -- there is absolutely no limit to what a D.O. can do in the military, compared to an M.D.

CBP: Well, you're evidence of that.

RB: Yes. [laughs] Of course, I'm not a surgeon, either. [laughs]

CBP: [laughs] When you were promoted to Brigadier General in 1991, you became the first D.O. to achieve Flag Officer status in the U.S. Army, which was clearly a personal milestone as well as a professional milestone. If the Army does not
distinguish between its D.O.s and M.D.s, which you've also assured me, my question is to what extent do you think the public, which includes perspective osteopathic physicians and patients -- even those of your osteopathic background -- views you as an ambassador of osteopathy.

RB: Leadership of the Army clearly knows I'm a D.O. I mean, there's no question about it. The then-Chief of Staff of the Army asked the then-Surgeon General when I made one star, "What's a D.O.?" and was educated on it. So I guess I'd have to say that in the regard of educating the leadership, that's pretty much been done. Sue Bailey was another one who was able to do that. Another one of our Brigadiers, Ogden DeWitt, is a D.O. Some of the Reserve Generals -- Dick Lynch, a 1966 graduate; John Kasper, a 1978 graduate is a General in the Reserves, and so forth. Leadership knows about D.O.s A lot of the patients know about D.O.s. A lot of the public still doesn't because Ronald R. Blanck, Lieutenant General, United States Army, the Surgeon General -- so what? D.O. M.D. They probably don't think about it. If they do, they assume M.D. So as much use as the profession can make of my position, I would certainly encourage
that, because it is a good story.

CBP: What is the profession doing to encourage that?

RB: A lot of interviews. A lot of speaking engagements, mostly at osteopathic institutions, however. But I speak -- I probably give three speeches a week, on average, to all sorts of civilian and military organizations. I'm a graduate of the Philadelphia College for Osteopathic Medicine. So that in itself is probably a bit of an advertisement. Perhaps even some education.

CBP: I have some questions now about military medical history as it pertains to osteopathy.

RB: Love it.

CBP: During the second World War and the Korean War, osteopathic physicians were not commissioned to serve in the Medical Corps.

RB: Right.

CBP: Why? And what role did the AMA play in policymaking for the DODs such that D.O.s were prevented?

RB: Well, it's not only the AMA, but it was all of organized/allopathic medicine in those days, which included the hospital association, the residency review groups, the ACGME. There was a forerunner, too -- I forget the name of it -- which was partially made-up of the AMA, but not entirely.
They have a different structure than the AOA, where everything sort of is under that umbrella. Specialty societies. By-and-large, osteopaths were looked upon as cultists and it was unethical to associate with them. So clearly, there was considerable political pressure to not have them commissioned as medical officers, which would have given them legitimacy. That actually, in my view, sort of played to the advantage of the D.O.s, because although many served in the enlisted ranks, many stayed here and practiced and took all the patients. An overstatement -- nonetheless that happened. So they gained strength in numbers, in patient support, and thus in political clout, which with the help, actually, of veterans organizations. President Eisenhower in 1958, which I'm sure you know, signed a directive that permitted -- it didn't mandate -- D.O.s to be commissioned as medical officers.


RB: Yes. Maybe it was 1957. Somewhere around there.

CBP: Well, I saw one place written that President Eisenhower signed legislation in 1958, yet it was in 1956 that Congress enacted Public Law 84763, and I believe that's when the President signed it.
RB: I actually can find that for you. I have it. I have all the files. I have all the medical files. It's sort of interesting. I have all the memos back and forth. As Chiefs, we don't want to do this. We'll lose our residencies, or it's not time yet, or the M.D.s won't work with D.O.s. It's sort of neat. I'm sure it wasn't in those days, but now looking back -- because you can see the thinking, and it must be the same thing that folks struggled for, for heaven sakes, with minorities, or with women in the military, which is still a big deal. It takes some getting used to -- what you've been climatized to, or a culture kind of thing. And so I give people a lot of credit for the little trouble or no trouble that I've had, for example, coming in in the time that I did. But whenever he signed it -- whether it was 1956 or -- I recall the law, and I believe you're right -- it was 1956. But I don't think he got around to signing it until 1958, until the directive came out. But anyway, whatever year it was, nothing happened on the basis of it anyway.

CBP: Right. That's my question, too. If the law was passed and Eisenhower signed it, and there was still a doctor's draft going on at that time, why weren't any D.O.s still drafted until 1967?
RB: Same resistance. Same resistance.

CBP: So passing a law didn't mean anything, then.

RB: Well, no. The law only permitted it. It didn't mandate. It didn't say you had to. So people resisted. People resisted.

CBP: Okay. I want to backtrack to World War II. I've read some mixed messages from things I've been reading, and one thing suggested that towards the end of World War II, D.O.s were allowed to have commissions in the Medical Corps, however, it never actually happened.

RB: I've never heard nor seen that.

CBP: No?

RB: And I've read several -- oddly enough, a lot of the students at the Military Medical School have taken as the history of medical project, the commissioning of D.O.s. And so they've done a fair amount of research on that stuff, and I've read all of their papers, because they used me as a source, and I've never seen that. That doesn't say it isn't so, but I've never seen it.

CBP: Well, I haven't been able to find anything to verify it. I've read it in some articles, but I wouldn't necessarily assume that those were documented articles anyway.
RB: Yes.

CBP: In reading an issue of PCOM's Digest from 1954, I found a reference to Dr. E. Anthony Sailer, who graduated from PCO in 1932, who held the rank of First Lieutenant, CAP, MC in the U.S. Air Force. Dr. Sailer was a flight surgeon of the Sommerville Squadron Civil Air Patrol, which was an auxiliary of the U.S. Air Force.

RB: Right.

CBP: If D.O.s were not yet being accepted for military service, how could this commission have resulted?

RB: Well, civil air patrol, though supported by the military, is not a military arm. And you have to look at the civil air patrol better than I know about it. They're nutty. They use the same titles as the military, but they're not military. So they could probably do it without the military doing it.

CBP: All right. In April 1966, Secretary of Defense, Robert McNamara issued a directive ordering the military to accept D.O. volunteers for active duty.

RB: Right.

CBP: In February of 1967, after the AMA House of Delegates lifted its objection to D.O.s being included in the draft, the first D.O.s were conscripted for military service. Why were the
military's and the AMA's attitudes towards D.O.s different when it came to the Vietnam War than they had been for Korea, for World War II, and for that ten-year period between when the legislation was signed that permitted them to serve?

RB: Well, a lot of people think it's because the M.D.s were getting tired of only them being drafted and losing their patients. I take a more charitable view that a few of the old folks whose opinions were never going to change died off, and younger people with whom many of the D.O.s have trained, as I've described at the Philadelphia Generals of the world, had interacted, had worked together, and the AMA by then was clearly -- partially on the basis of fearing lawsuits -- changing its position on osteopathic medicine saying, "Well, maybe it isn't so bad. Maybe it does have some science to it. Maybe not the OMT part of it, but everything else is okay." So it was clearly a climate of change, and the time had come to do that. Now, you can make an argument, and I would make it very strongly, that the time probably was way before then. But there you are. And so at least at that time a confluence of factors was such that they did it.

CBP: Do you think that the almagamation of the D.O.s and
the M.D.s in California in 1962 had anything to do with demonstrating that there had to be acceptance of D.O.s if California was willing to have them merge?

RB: Probably, if we were going to give them . . . . Yes, right.

CBP: But how could you then treat them differently if five years before that, you're willing to take them and hand them your own degree?

RB: Yes. Of course, organizations aren't always bound by consistency, but yes, that's right. I think that did have something to do with it.

CBP: In 1987, the DOD issued a new policy recognizing the AOA's specialty certification process. Could you please explain this policy and its significance?

RB: Well, actually, they were recognized before, but I think were not specifically included in the regulation, and the significance is that people were paid specialty bonuses on the basis of certification, and the certification was on the basis of ACGME, the Accreditation Council of Graduate Medical Education, which is the oversight body for allopathic boards. So we needed to include the osteopathic boards, as well, specifically.

CBP: Were they grandfathered in, then?
CBP: In August of 1989, as required by Public Law 100-80, Selective Service sent an operational concept for a standby health care personnel delivery system to Congress. The new plan would induct men and women D.O.s under age forty-five within ten days of mobilization order instead of the months it took under the doctor's draft in effect from 1950 to 1973, and no physicians would be allowed to apply for deferment or exemption until receiving an induction order. What did Congress do with this proposed plan, and what is the significance of this directive, if anything?

RB: I don't know.

CBP: You don't know what Congress did with it?

RB: No.

CBP: Are you familiar with this change to shorten the mobilization?

RB: Yes, vaguely. I think they did it for all physicians. In effect, I think it includes more than physicians. In other words, not just D.O.s. And I think it's still in the books, but we didn't
use it -- even in Desert Storm. I mean, I guess we could if there would be a huge national emergency or something like that.

CBP: Have there been any other significant acts or directives impacting military service for D.O.s that I haven't touched upon here?

RB: No. I think you got them all. One or two of the Medicare Health and Human Services programs by omission don't include osteopathic physicians and that by and large has been addressed, but it has no effect on military D.O.s anymore.

CBP: I asked you before, but can you just repeat the answer for me, please? Approximately what percentage do you think of the D.O.s in the Army or in all the Armed Services -- of all the physicians in the Armed Services --

RB: I said fifteen to eighteen percent, and that may be a tad high, but it's considerably higher than -- are we at ten percent yet -- maybe not that -- of osteopathic. No, we're about eight percent, I think.

CBP: Eight percent.

RB: Yes, we're more than that. Maybe it's only twelve or fourteen, but it's significantly higher.

CBP: Do you know what the strongest representative of
that is in the Army or different branches of the Armed Services?

RB: I do not. The Navy has been particularly hospitable to D.O.s, and I'd like to think that the Army has, as well. The Air Force certainly has no Generals, and doesn't appear to have anybody -- at least on the verge of it -- at this point. But that may be happenstance more than anything.

CBP: In your opinion, is the military currently a good place for D.O.s and why?

RB: Oh, I think the military is a good place for D.O.s, just like I think it's a good place for any physician or generally any health care provider, with the proviso that you have to live by certain relatively specific rules, and you're not going to get rich. You'll do okay. The rules have to do with uniforms and P.E. tests and all of that. So there's a culture that you have to fit in, and if you're somebody that likes to go around with sandals and not be particularly structured, you'd be really miserable in the military. Once you get past all of that structure -- those rules -- you find, I think, enormous freedom to practice medicine to the best way possible. It's not to say we're not under U.M. and all of the other kinds of constraints, but we
really have a value of service and of quality patient care, and so we can keep people a little bit past when the standard would say to discharge them if we want to, and all of that. Whereas sometimes the constraints in the outside aren't that so. We are bureaucratic, but trying to deal with that. We have the advantage of systems that cut across, so when you move -- and there is movement -- that's part of it -- from one place to another -- you're in the same familiar system. The other two things about it have to do with opportunities -- clearly as a clinician, also as academician. Clinical academics or even classroom academics at the medical school -- or in research, as well -- and then you have the additional possibility of staff and command kinds of things as certainly I've done after I did my clinical and academic stints. You don't have to do that. You never have to be a commander or give up your clinical practice. Many people spend twenty or thirty years in the military as clinicians, as academicians, and, in fact, become world-renowned in various areas, so there are those opportunities. But with that separately. And then finally, there's something else about the military that I found in Vietnam and that was they're a group that believe in
the same things I do, and that's the value system. That quality system -- people focus in orientation now. We talk it more than we live it, I suspect, but it's still a very, very powerful force, and we are very much a family. Spread out over half the globe, but there's an esprit, a camaraderie. And everybody -- even those who didn't particularly like the military that I've talked to who has gotten out -- says, "You know, the one thing I miss is the sense of sharing, the sense of being in it together, and there isn't that in the outside." That's probably not true. I'm sure there is that in the outside.

CBP: You just find it in other communities.

RB: Yes. I don't know. The military is a special one. I think so, and I have a certain prejudice, I'm sure. But that's why I said -- those are the reasons I think the military is a good place for D.O.s.

CBP: What trends do you see in military medical careers as we approach the twenty-first century?

RB: Increase in technology, less inpatient care, lighter, more mobile forces required for deployment. I'm actually developing surgical teams that jump with backpacks that have all their surgical
equipment. Right now we do telemedicine and we have a paperless medical record. Two-megabyte chip that locates patients that we put on what we do to them in a special reader.

CBP: Is this like a dog tag system?

RB: Yes, except it has a chip in it -- exactly. So we're doing that now -- today -- in Bosnia. So there are all sorts of those kinds of innovations. Opportunities jump out of perfectly good airplanes if you want to do that. Just lots and lots of things going on. But the difference is it will be small, it will be light, it will be technical -- technically heavy. It's going to be things that we haven't even thought of. Much, much more of the managed care kind of thing. For us managed care facilitates care, doesn't deny it. But that's the way that we look at it in the military. But what is unchanging are those values and our core functions.

CBP: I understand that there is a medical scholarship program here, at PCOM.

RB: Yes. Health Profession Scholarship Program. PCOM is one of the largest in the country, actually.

CBP: Do you have some sense of how many students in PCOM are currently going through PCOM on that scholarship program?
RB: Hale knows specifically -- or Ken Veit. Let's see. We usually commission anywhere between twelve and eighteen a year in the Army. The Navy usually has ten or so, and the Air Force four or five. Every class has probably close to forty, as a ballpark, so that's somewhere between a hundred and twenty and a hundred and sixty, I would bet.

CBP: Do those students have to do any type of military training during the course of the four years that they're at PCOM?

RB: Yes. They have to go through -- unless the school is structured such that they don't have time to do it -- they have to go through a basic for us at Fort Sam Houston, and then we expect them to do two summer rotations -- ADTs -- active duty for training.

CBP: While they're a student?

RB: Yes.

CBP: And they have the skills to do a rotation already?

RB: Yes, sure. They're a student at Tripler or Walter Reed or someplace. Yes, we have hundreds of students all over the place.

CBP: If I were writing a chapter in an upcoming centennial history book about the military, which PCOM graduates, other than yourself, do you think I
should highlight and why?

**RB:** Jim Black, Admiral; Hugh Scott, Admiral; Sue Bailey, Navy Reservist also has been the Deputy Assistant Secretary of Defense, and might have that job I spoke of as the Under-Secretary. Other graduates -- probably folks like Sprague Taveau, Class of 1977, who was in infantry and then came to school and went back out and served in the role as a military physician and really did some great things for us. Those are the ones that come to mind offhand. There's a few others. There was an Air Force graduate here who then was the head of emergency medicine. There's academic folks that also have been graduates here who you could find out about. You really need to talk to Hale. He has probably a better sense of where folks are now, than I do now. I mean, I know them in the Army, but I don't know them in all the other Services.

**CBP:** How long did you serve on the Alumni Association Board as the military representative?

**RB:** Five years -- something like that.

**CBP:** How would you describe your role in that position?

**RB:** Come together twice a year, and hear about where things are going in the school. It was very contentious between the administration and the board
when I first started, and that has gotten much, much better.

CBP: So you started shortly after the transition into Dr. Finkelstein's Administration?

RB: Yes. Apparently Tilley before him -- whoever it was.

CBP: Have relations with the Alumni Association been mended with the administration?

RB: Yes. You get into fund raising and capital campaign going on now. I think it's a neat organization. It doesn't take a heck of a lot of time, but it continues the involvement of the graduates in the school and serves as sort of a facilitation and communication with other graduates.

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

RB: Well, overall, turning out the number of graduates with quality education and for all the problems that I've described -- particularly in my years with clinical education -- the education was excellent, I think. So largely that's it. Certainly its role now without a hospital of its very own -- and there's other schools that don't have hospitals, either -- but now really setting as its core competency education. It's doing a lot of things
that can serve as a model for the profession, also. A lot of full-time faculty members. We have a real problem in the profession as having half part-time faculty members that don't know how to teach.

CBP: Other schools, in addition to PCOM?

RB: Oh, yes. Oh, I think PCOM is much better than some.

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

RB: Oh, keeping itself relevant. Getting into distance learning.

CBP: What do you mean by keeping itself relevant?

RB: Providing the education that the students will need ten and fifty and twenty and thirty years from now. It's easy to still teach the way that we've taught, and that might have little to do with what people need to have learned then. Computers, technology, distance learning, CME -- all of that kind of stuff. We're faced with the same thing in the Army.

CBP: That concludes the prepared questions I have for you. Is there anything else you would like to comment on that I haven't asked that's relevant to this discussion, or something that's not relevant to this discussion that you'd like to say?

RB: No, I don't think so. I think you've covered just
about everything. Oh, yes, I will add one other thing, since this is kind of an historical perspective, I suppose, or for archives. One of the things that was fascinating was dealing with the Soviets in Berlin, and there are stories. But I also was the Medical Officer for Spandau Prison, and pronounced Rudolf Hess dead, when he managed to hang himself at age ninety-three. I've always said I want to go to Israel and see if people buy me beer. I bet they will. [laughs] Hess was an interesting man. I've read a lot about him.

CBP: Had you had any exposure to him, other than being there to pronounce him dead?

RB: Oh, yes. Sure. I saw him every month for a year-and-a-half. We used to chat a little. Not much.

CBP: About his mental health?

RB: Well, no. About his health in general and about tennis or about the rocket program -- Moon Program America. He tried to keep up on things. He never seemed crazy in the conventional sense, to me.

CBP: What's going through my head is could you see a monster underneath all of that?

RB: No. Yet he clearly was. But no, you could never tell that.

CBP: He fooled a lot of people. He could fool you, too.
RB: Oh, yes. That's right. He was never convicted of war crimes because he was a prisoner during almost all of the war. He parachuted into Scotland in July of 1940, but he signed most of the decrees that incarcerated a whole population. He was convicted of crimes against humanity. That's why he was never released. Plus, the Soviets thought that he was trying to get the West on the side of the Germans to attack Russia, which, indeed, he was. I never forgave him for that.

CBP: He got off easy just spending his life in prison.

RB: Yes.

CBP: Anything else?

RB: No.

CBP: Thank you very much.

RB: My pleasure.

End of Interview
Alumni Association ........................................................... 62, 63
Archer, Marge ................................................................. 16
Army Medical Department Center and School .................. 42
Army Surgeon General .......................................................... 41, 42
athletics ................................................................. 22
Atkins, Anita ................................................................. 24
Bailey, Sue ................................................................. 44, 62
Barth, Frederick ............................................................. 14, 15
Black, James ................................................................. 62
California crisis ................................................................. 54
career, military ................................................................. 32, 34, 35
Cathie, Angus ................................................................. 3, 11, 23
City Line campus ............................................................... 6
class notes system ............................................................. 23
clinics
20th and Susquehanna ...................................................... 7
Embreeville State Hospital .................................................. 12
Harbor Light Clinic ............................................................. 12
North Center ................................................................. 9, 11
curriculum ........................................................................ 4
d’Alonzo, Albert ................................................................. 24
DeWitt, Ogden ................................................................. 47
Eisenhower, Ike ................................................................. 49, 50
England, Robert ............................................................... 11
Fort Sam Houston ............................................................... 5
Greenwald, Morton ............................................................. 3, 23
Guest, George ................................................................. 13
Gulf War ........................................................................ 39, 39
Health Profession Scholarship Program ......................... 60, 61
Hess, Rudolf ................................................................. 65, 65
home deliveries ................................................................. 13
Hospital
48th Street ..................................................................... 4, 6
Kennedy ................................................................. 7
Lancaster Osteopathic ........................................................... 25
Philadelphia General .......................................................... 6
Kasper, John ................................................................. 47, 47
Korean War ................................................................. 48, 48
Lynch, Dick ................................................................. 47, 47
Mercer, Sherwood ............................................................. 14
Misercordia Nursing School ............................................... 17
Nicholas, Nicholas ............................................................ 11, 24
OMT ........................................................................ 11, 12, 28-30
osteopathic physicians
and military, generally ..................................................... 27, 57-59
conscription ..................................................................... 53
percentage in military ...................................................... 37, 56
political clout .................................................................. 49
prejudicial treatment ....................................................... 45, 46, 48, 49, 51
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pierson, George</td>
<td>15</td>
</tr>
<tr>
<td>plague</td>
<td>29</td>
</tr>
<tr>
<td>Public Law 84763</td>
<td>50</td>
</tr>
<tr>
<td>reduction in force (RIF)</td>
<td>40</td>
</tr>
<tr>
<td>residency</td>
<td>32</td>
</tr>
<tr>
<td>Rowland, Thomas</td>
<td>14-16</td>
</tr>
<tr>
<td>Sager, Marshall</td>
<td>18</td>
</tr>
<tr>
<td>Sailer, E. Anthony</td>
<td>52</td>
</tr>
<tr>
<td>Scott, Hugh</td>
<td>62</td>
</tr>
<tr>
<td>Sharf, Jerry</td>
<td>4, 24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Employment</td>
<td>17, 19</td>
</tr>
<tr>
<td>Hayes Home for Men</td>
<td>17</td>
</tr>
<tr>
<td>Videon Funeral Home</td>
<td></td>
</tr>
<tr>
<td>Student Life</td>
<td>16-19</td>
</tr>
<tr>
<td>Atlas Club</td>
<td>19, 20</td>
</tr>
<tr>
<td>fraternities</td>
<td>20, 21</td>
</tr>
<tr>
<td>marriage</td>
<td>21, 22</td>
</tr>
<tr>
<td>transportation</td>
<td>18, 19</td>
</tr>
<tr>
<td>student/faculty relations</td>
<td>15, 22, 24</td>
</tr>
<tr>
<td>surgery, ambulatory</td>
<td>39</td>
</tr>
<tr>
<td>Taveau, Sprague</td>
<td>62</td>
</tr>
<tr>
<td>telemedicine</td>
<td>39</td>
</tr>
<tr>
<td>training</td>
<td></td>
</tr>
<tr>
<td>clinical</td>
<td>8-11</td>
</tr>
<tr>
<td>psychiatric</td>
<td>13</td>
</tr>
<tr>
<td>tuition</td>
<td>37</td>
</tr>
<tr>
<td>Veit, Kenneth</td>
<td>25</td>
</tr>
<tr>
<td>Vietnam War</td>
<td>4, 25, 27</td>
</tr>
<tr>
<td>and D.O.s</td>
<td>5</td>
</tr>
<tr>
<td>Walter Reed</td>
<td>38, 39</td>
</tr>
<tr>
<td>War College Senior Service School</td>
<td>34</td>
</tr>
<tr>
<td>Wolf, Jimmy</td>
<td>16</td>
</tr>
<tr>
<td>World War II</td>
<td>4, 48, 51</td>
</tr>
</tbody>
</table>