First Question - What inspired you to go into public health after your medical schooling?

My interest in public health came through an interest in syphilis control, which started very early in my life, even before I entered medical school. While I was in medical school, or while I was in the college at the University of Pennsylvania, I worked as a technician to partially support my schooling.

One of the positions that I got very early, in my sophomore year in college, was with Dr. John H. Stokes, who, it so happened, was an internationally famous expert in syphilis control. As a matter of fact, during World War I, Dr. John H. Stokes had written the manual in syphilis control which was used by the United States Army. During the subsequent years, was a constant consultant to the United States Army, and when the League of Nations formed its health organization, and took one of its first projects, the control of syphilis and venereal disease throughout the world, Dr. Stokes was chosen as the representative of the United States on the League of Nations health organization for that purpose.

And it was during this period that he was attending meetings in Europe, and during this period also that the League of Nations started to compile clinical research data in the treatment of syphilis. And while I was in the college, I was employed by the League of Nations in compiling such data.

This remained as kind of a hobby, or avocation for me, right through medical school. When I was in medical school I did constant clinical and library research in syphilis, as a hobby in my spare time, and spent all my summers in the College of Physicians library, as in my sophomore year in medical school, I wrote an article on the life cycle of Treponema pallidum, which is the causative organism of syphilis, which gave me international recognition. I had correspondence with many of the leading research workers in Europe, and others. And as a matter of fact, later on...as late as 1945, when Mahoney was doing his research on the causative organism of syphilis with the electron microscope, which had just recently been developed, he had reproduced in its entirety,...it was reprinted...the article
which I had written in 1932, because it was no longer available, as being the outstanding, definitive article on that subject, up to then.

Also, while I was in medical school, I developed my basic interest in the prevention of congenital syphilis, through the treatment of the syphilitic pregnant woman, and then early diagnosis of infantile, congenital syphilis. And syphilis is one of the diseases...one of the few diseases, other than viral diseases, which is transmitted from parent offspring. And the ravages of infantile congenital syphilis during those days, when syphilis was not a very treatable disease, was very great. And this is where I really developed my interest in the field and became an international authority in the treatment and prevention of congenital syphilis.

Immediately following my internship at the Philadelphia General...well, during my internship at the Philadelphia General Hospital, as a matter of fact, in further indication of my interest in this field, I saw the ravages of infantile congenital syphilis on the population in that hospital, where they had about 10 to 12% incidence of syphilis among pregnant women.

(WMP: At the University of Pennsylvania Hospital?)

No, the Philadelphia General Hospital, where I interned. And, at that time, with the consent of Dr. William Turnbull, the superintendent of the hospital, I established, for the first time, and ran, as an interne in the hospital, the clinics for syphilitic pregnant women and for the offspring of syphilitic pregnant women, and infantile congenital syphilis.

And to the extent that when I completed my internship there was no one to take over the clinics, and fortunately, since I was staying in town, they were forced to immediately appoint me to the staff of the hospital, to continue the work, since no one else was doing that.

As a result of that, I published a basic paper on the diagnosis and treatment of infantile congenital syphilis, which won the interne's prize essay, and which also was published nationally, and just as an interesting sidelight, when Joseph Earl Moore, who was the editor of the journal that accepted it for publication at Johns Hopkins University, found that the paper had been prepared by an interne, he tried to influence me to take my ...the recognition of "interne" off the paper, because he felt that it would detract from its authoritativeness, which I refused to do.
Well, in those days syphilis was treated by what are known as the arsphenamines, neoaarsphenamine, and heavy metals, bismuth... provided a woman was detected... provided a woman was found to have syphilis, and treated before the fourth month of her pregnancy. That is, well, there's reasons for this that I don't need to go into, but provided she started treatment that early in the pregnancy, she had virtually 100% chance of having a healthy child. The later in pregnancy you went, the more likely the fetus was to be infected. And the fetus was almost always infected if the woman had active syphilis and she went to the seventh or eighth month in her pregnancy without detection and treatment.

And the disadvantage of the arsphenamines and the heavy metals were that they penetrate the placental membrane that separates the mother's from the child's circulation with great difficulty. So that once the fetus is infected, you have very little chance of having the disease stopped in utero. That was what the situation was at that time.

So that there was really effective treatment, but the effective treatment depended upon the detection of the disease in the mother, early in the pregnancy, and then adequate treatment right through the pregnancy.

(WMP:) Is there any way of helping the mother to get over it?)

Well, the treatment of syphilis in an adult with the arsphenamines and heavy metals required about eighteen months of continuous treatment. And one of the principal problems in those days was keeping an individual interested and under observation regularly for that period of time.

So that the cure rate for syphilis, even under the most favorable circumstances, was not as great as it could have been, and one of the principal things which was necessary to do was to try to bring the individuals back for treatment over that period of time. So that was the disadvantage of the older treatment. The treatment was... the drugs that were used were toxic drugs. They were a little more toxic for the syphilis organism than they were for human beings. But they're really... I mean an arszenobenzoyl is a toxic drug.

(WMP: This may be a little off the technical subject, what finally developed the treatments that they do have now?)
Well let me get going and I'll come to that, because I was involved in all of that.

(WMP: Oh fine.)

Immediately following my internship, I went to the University of Pennsylvania to take up dermatology and syphilology. Syphilology was attached as a specialty to dermatology, so that the Boards were the American Board of Dermatology and Syphilology. So I went to train, again under Stokes; I went back to Stokes to continue my training at the University of Pennsylvania, he being the professor there.

In 1936, immediately after... that is, after I had been in training for about a year, the head of the venereal disease division of the state of New Jersey, who at that time was a very well-known laboratory man, Dr. A. J. Casselman... I think Dr. Casselman's still alive... he's in his nineties, probably... was the head of the venereal disease division, part-time. He worked part-time as the head of the laboratory in Camden, and part-time as the head of the venereal disease division in Trenton.

It was evident that with increasing interest in the control of syphilis, that it would be necessary to have a stronger program and a full-time individual. He approached Dr. Stokes and asked Dr. Stokes for an individual to go full-time to New Jersey to head up the venereal disease division.

By agreement I went to New Jersey on a leave of absence from the University of Pennsylvania. It was Casselman's idea that I would eventually become head of the... full-time head of the division, replacing him, and he would serve as consultant.

It was my idea and Stokes's idea that I would go temporarily until we got them organized, so I don't think we ever saw... ... had a complete, frank understanding, from that standpoint.

It so happened that in December of that year, that's December 1936, that Surgeon General Parran, United States Public Health Service, started his... in this country... the national venereal disease control movement... or really, that was started with the national syphilis control movement, and gonorrhea was brought in subsequently.

(WMP: Well the federal government must have gotten into it deeply, then.)
That's right. They had surveyed...I mean, there had been some programs in Europe, particularly in Sweden, where they had made... they had sent a committee to Europe and whatnot; he came back and made this report, and they had the launching of the National Syphilis Control Movement, which subsequently became the National Venereal Disease Control Movement in December of 1936.

I participated in that meeting in two regards. I had sufficient reputation in prevention of congenital syphilis and whatnot, that what I presented that subject; in addition to that, I prepared the epidemiologic work that I'd done in New Jersey in the preceding year. In other words, finding the incidence of the disease, and also the case-holding ability...they used to call it the case-holding ability...to keep the individual under observation and I had studied Atlantic City and Patterson, New Jersey and all around through New Jersey as to how well they were keeping their patients under treatment. And I think a place like Atlantic City in those days held about 10% of their patients to full treatment....I mean, showing how many were not receiving adequate treatment.

Following this meeting, the surgeon general realized that he had to train and re-train individuals to do venereal disease control work in this country. He had to train physicians. He had to train nurses. He had to train social workers. He had to train all types of individuals who had been inadequately trained before, and he had to train many new individuals. And he asked Dr. Stokes to set up the Institute for the Control of Syphilis. It became a federally financed program at the University of Pennsylvania.

And Dr. Stokes, who himself was so busy that he couldn't possibly devote the time necessary to do this all the week and supervise it, asked me to come back from New Jersey to serve as the administrative head of this organization.

(WMP: What point in time was this?)

This was in February, 1937. And so I forthwith left New Jersey and came back and organized this program. And I worked... ...this program was completely federally financed, having started out as... the Institute for the Control of Syphilis... it subsequently became known as The Institute for the Study of Venereal Disease. And I remained as the administrative head of that organization as long as it existed, which I think was up until 1953 or 1954. And when Stokes retired from active head of the organization, I then became the head of that organization and phased it out.
Now this organization did the work in Philadelphia for what was known as the co-operative clinical group, which was an organization also set up by the United States Public Health Service, to study the treatment of syphilis and to develop the treatment of syphilis, throughout the country. And this consisted of five principal medical organizations throughout the country. The University of Pennsylvania was one. Johns Hopkins was one. The Cleveland Clinic was one. The Mayo Clinic...the University of Michigan was one. Let us see...the fifth clinic kind of escapes us for the moment. And I mean, there were five clinics involved.

Now, one of the things which they did in this co-operative clinical group in the United States, was to develop the use of penicillin in the treatment of syphilis.

(WMP: When did that come along?)

Fleming had discovered penicillin in England, prior to World War II. But because of the ravages of World War II, it was developed commercially in the United States: it couldn't be developed commercially in Europe.

The first penicillin was developed commercially in the United States about 1943, I guess. It was known to be effective against, infections like pneumonia, pus-forming diseases and so forth. But it was Dr. Mahoney who ran what was then a world famous and probably one of the best research centers for syphilis in the world at the Staten Island Marine Hospital.

And he was the individual who did the animal investigative work to show that penicillin was effective against the causative organism of syphilis. Very effective.

And it was the co-operative clinical group that tested penicillin on human beings with syphilis. And the principal, Again, because of my interest in syphilis and pregnancy, and congenital syphilis...that aspect was assigned to the University of Pennsylvania. And I personally treated the first syphilitic pregnant women that were ever treated with penicillin and followed through their results. And that-nat.

And we also, with the help of the obstetrical department, studied the permeability of the placenta to penicillin, and contrary to the drugs which were formerly used in the treatment of syphilis, which penetrated the placenta with great difficulty, penicillin goes right through the placenta. So
that, not only does penicillin treat the mother and cure the mother, it also, if the child is infected, even in the seventh or eighth month of pregnancy, immediately treats the child in utero. So that, there with the advent of penicillin, except for very unusual circumstances, congenital syphilis ceased to exist.

(WMP: Did you get any honors for doing this?...recognition?)

Oh no. Well, I got this type of recognition. When...in 1950, I guess it was, when Europe was recovering from World War II, and they began to manufacture penicillin in Europe,...I mean they just had their first plants to manufacture penicillin in Europe at about that time, 1949...1950,...the World Health Organization....I forget whether it was then the World Health Organization or whether it was the League of Nations....I guess it was the World Health Organization, although the health contingency operated from Geneva in Switzerland....I, along with three other individuals, were called to active duty as so-called traveling consultants of the World Health Organization to introduce penicillin in the treatment of syphilis to Europe.

And the other individuals in this organization....I covered syphilis and pregnancy and congenital syphilis; Reim, from New York City, covered early infectious syphilis, that is primary and secondary stages of the disease; Bäther, who was a world-reknowned neuro-syphilologist from Vienna, who had come to this country, served as the individual in neurosyphilis. And Pangborn, who was an experimental serologist from the New York State Laboratory, went along in terms of diagnosing the disease...serologic testing and so forth in diagnosing the disease.

And we traveled throughout Europe and lectured in what would be the equivalent of the national and county medical societies, going to Finland, Norway, Sweden, Denmark, Netherlands, France, and what not, and in certain of these places, such as in Paris and in Helsinki, we held what would be national meetings, or international meetings, in which individuals came in from all the rest of the countries, like Britain and Spain and Italy and Greece and so forth and so on. And this was really the first introduction which these physicians of Europe had with the results of the treatment of syphilis with penicillin.

And all of this is ....I mean, all of these papers and so forth, are published in the Acta Dermatologica Scandinavica.

(WMP: You should have gotten a Nobel Prize. Did you....)
No. Well, I mean, I got...the type of things which you get as a result of this, you become honorary members of the societies over there and so on, so that I'm an honorary member of the French Society of Dermatology and Syphilology, and an honorary member of the Finnish Dermatology and Syphilology Society and so on. I have a little....in fact, I never even had them framed, but I have....that's the type of thing...I'm not given.....well, I mean, I don't think that I did anything more than lots of other individuals do, and as a matter of fact, we were permitted to do this principally upon the happenstance that penicillin was manufactured in this country, and not in Europe and so on.

Well.....

(WMP: It's a great story. I don't mean to interrupt you, but I think it's terrific.)

No. Well, during this period and up to the time that I came with the Health Department, I was a national consultant and I think probably the principal national consultant of the United States Public Health Service in syphilis and pregnancy and congenital syphilis. And whenever they had national meetings or educational meetings, I was always the one to go and present this particular subject. And I was kept on per diem basis, and so forth and so on, during that...for that purpose.

(WMP: You've done such a good job of stopping syphilis the people who read this record someday, may not realize how extensive it was and how widespread syphilis was in the United States and other places. Do you want to say a few words about that?)

Well, the principal thing that made syphilis such a problem in those days, was the fact that so few of the cases that acquired the disease were actually cured because of the difficulty of the treatment. So that there were very large numbers of individuals with syphilis in the population all the time, and particularly in populations which were lacking in educational advantages and therefore more exposed and likely to get syphilis.

The incidence of the disease approached in some segments of the population, 10 and 15 and 20% of the population were involved. And because of the large numbers of individuals who needed to have treatment over periods of years, the clinics in a large urban center were horrendous!! A syphilis clinic at the Philadelphia General Hospital would have two hundred and fifty patients, two or three times a week. And they would run them through just as fast, all afternoon.
And the University of Pennsylvania, which actually had a smaller population than the Philadelphia General, would have half-day clinics, five days a week, and would have large numbers of patients in each of those clinics.

Syphilis, unfortunately, no one has ever been able to find any way to immunize against syphilis. So that any time an individual is exposed to infectious syphilis, they will acquire the disease, and in spite of the fact that ever since the early 1950's, they've talked about eradicating the disease, among younger and sexually promiscuous individuals, there is still an appreciable number of fresh infections.

(WMP: But they can be cured.)

The one thing that you don't see, or hardly ever see these days, are the ravages of late syphilis. Syphilis is a disease of the reticuloendothelial system. It exists in the lymphatic tissues and in the lymph nodes and then goes in showers in a few organisms in the blood stream for the rest of the life of the individual, as long as they're there. It gets in the nervous system and once it gets in the nervous system, it's again protected by a membrane through which the spinal fluid filters so that it's very hard to penetrate... for the argeno-benzoyls to penetrate the nervous system, so that it was very hard to treat a nervous system syphilis in the old days, and you used to see cases of paresis, so called, tabes dorsalis, locomotaxis, ataxia, and many individuals died of syphilitic heart disease, aortic regurgitation, aneurysms, and what-not. That type of thing is almost unheard of these days. And anyone that gets treated with penicillin can be cured of the disease. Being cured of the disease, you can be re-infected.

(BF: There's no immunization for it.)

No. It doesn't develop an immunity. You see, one of the reasons they developed, during one stage in the Public Health Venereal Disease Control Movement, the routine blood serologic test during pregnancy was to detect syphilis. And provided a woman was treated during pregnancy, there is virtually no chance that the child will be infected.

And, by Philadelphia, by 1952 and 1953, we went through some years, even with, you might say, imperfect syphilis control, of having... we went through one year with no cases of congenital syphilis in the city at all, and most other years there were two or three cases. And those would be cases in which they probably had no pre-natal care at all, when you see here.
Well now, let me just start with my relation to the Health Department. At the beginning of World War II, the surgeon general was very much concerned with the exposures of individuals in the military service to venereal disease, including syphilis and gonorrhea in the United States. I mean, not only in foreign countries but in the United States because the diseases still had an appreciable incidence in the United States...in those days, which was before penicillin.

And so they...the United States Public Health Service, which was making away...I mean, really following the surgeon general's, that is, Surgeon General Parran's campaign to control syphilis, starting in 1936, each year from then on the federal government began spending more and more money and while billions of dollars which we talk about being spent for health care were not spent in those days, and the initial syphilis control program as I recall in 1936, on a national basis, had about three million dollars, and in the next five or ten years got up to about fifteen or seventeen million or twenty million dollars. This was a pretty adequate amount of money for what was necessary in those days when everything was a lot cheaper than it is now, including salaries and everything else.

And the assistant surgeon general of the United States Public Health Service in charge of venereal disease control, who was Dr. R. A. Vonderlehr, had to stimulate the various centers...where the military trains came through and congregated to control the disease. And one of the places that was stimulated was Philadelphia. R. A. Vonderlehr approached the state secretary of health, who in those days was a Dr. Shaw, and asked him to appoint a venereal disease control officer for the city of Philadelphia. And after some negotiations, I who was at that time serving as the administrator of the Institute for the Study of Venereal Disease, agreed to organize the venereal disease control program in Philadelphia, which I did. So that I was, first of all, appointed to...no, I guess I was already working with the public health service, when I was assigned by the public health service to the city of Philadelphia.

(WMP: Who was the head...director of health service? )

Hubley Owen. Hubley Owen was the Director of the Philadelphia Department of Public Health.

(WMP: He was a pretty good man, wasn't he?)

Yeah...very good, and he was particularly good in the type of thing which we were trying to do. I mean he had a good interest in public health work, quite a good deal of knowledge about the social and other problems, and...Well anyway, Shaw agreed and Hubley Owen agreed to appoint me to organize the program, and after one year of organization under the public health service, legislation was introduced into
City Council, and the first city appropriations given to venereal disease control, which were matched, actually in those days in this... I mean this was the... one of the earlier federal programs in which there were federal matching funds. And the federal matching funds were quite significant. I mean, I believe they matched around fifty percent in those days. And so that, I became the first head of the venereal disease control program and continued as head of the division until the reform administration went in in 1952.

Now during the time that they were developing the charter, and during the time when they were performing the public health survey, which was the 1949 survey, on which Clark based his health program action, the... Rufus S. Reeves was the commissioner of health. Rufus S. Reeves had had no particular training in public health and not any particular experience in public health. His background had been in the practice of medicine and in nutrition and he was a former president of the Philadelphia County Medical Society and what-not... was well-known physician in Philadelphia, but without experience in the public health field.

And through my exposure and working in the public health service and what-not, I have learned a lot about health generally, and as a matter of fact, no less than Sir William Osler is quoted as saying... to know syphilis in all its manifestations, everything in medicine is open to you.... That is, it's so varied and requires so much knowledge and different approaches, that it is a good training ground for almost anything. That is, as a disease, you see, it affects all organs, and in public health control it also affects many methods.

Well, Rufus Reeves assigned me to do such health representation as there was in the various committees and so forth... with the charter. He also assigned me to start... and this is prior to the Clark administration, since this was in 1949, the implementation of some of the things in here, which... one of the things that was recommended... was going over from a specialized program, in which you had a tuberculosis division, a venereal disease division, a child health division, and so forth, and in this division there was public health nurses for venereal disease, public health nurses for tuberculosis control, public health nurses for maternal and child health, in these separate divisions, each division was a unit in itself. We had our own medical staff, our own nursing staff, our own clerical staff, and we also operated from separate locations... so that there would be, you know, nine or ten venereal disease clinics spread around through the city, and fifteen or twenty maternal and child health clinics... and they would all be wherever they came up through happenstance, and most of them were in storefront locations or in renovated houses.
so that there'd be a room or two and various individuals who
went around at the clinic at this part of the city on this day, and that part of the city on another
day, and what-not. So that the clinics were not continuous,
in any sense of the term, but functioned one or two or some­
times three times a week, and for an hour or two. And that is
the way in which health was delivered.

That's not to say that the city wasn't pretty well covered by
a large number of clinics independently administered with a very
difficult co-ordination and probably a great wasting of health
resources.

Well, one of the basic things which was attacked and this was
immediately, was that type of a program....the idea being that
you should generalize your public health program...that nurses
should do all aspects of health work rather than just venereal
disease control, or just tuberculosis control....that you should
have public health physicians...that you should have a central
administration...that you should have ...clinics located so
that all of these things work together in a single building.

There were two experimentally health centers in Philadelphia,
prior to this report, and prior to the program which was really
instituted under the reform administration. And these were...
the 20th and Berk Health Center, which was set up under the
Rosenwald Fund, in a renovised police station at 20th and Berk
Streets. And that, I guess, you might say, was the first at­
tempt at bringing together under one roof the various public
health functions for a part of the city.

A second program....

(WMP: What year would that have been?)

Well, I can't give the....it was in the 1940's, but I can't
say exactly when. I can't give it more accurately than that.
But that's something that could be looked up.

Another attempt along this line, was what was the Fife Hamel
Memorial Health Center, which was set up under the auspices of
Jefferson Medical College, by Dr. Perkins, who was the dean of
Jefferson Medical College at the time, and a well-known public
health individual, who had a strong background, I think in
missionary medicine or what...in China. And he had there been exposed to the idea of treating
a family to prevent illness, rather than to treat illness once
it occurred. And so that one of his missions at Jefferson Medical
College, which he strived to do, not too successfully, as a matter of fact, was to try to set up an organization which would treat families to keep them well.

And in order to do this, he conceived the Fife-Hamel Memorial Health Center, which was set up as a part of what used to be the Babies' Hospital at 7th and Delancy, or someplace, it was down there somewhere...I don't remember what the exact address was. And in order to do this, he brought to Philadelphia, from New York City, which at that time had a few district health centers, an individual by the name of Bernard Blum, who was a qualified public health individual, and one of the first...you might say...qualified public health individuals, to come to the city of Philadelphia. And that was in the late 1940's, I guess, probably, immediately following World War II.

So that those two were functioning at this time. And the program in the city of Philadelphia had these as examples, so the speak, to start on, at the time that Dr. Reeves assigned me to try and get something underway.

Well, we immediately became involved in dollars and cents problem and the politics of the situation, so far as serving the community is concerned. And I don't claim to be an expert in backfield...particularly at that time, and I don't know if I ever became too expert, even as health commissioner, but it was the feeling of the health authorities that we would set up a model health center to cost somewhere between a million and two million dollars, which in those days, was a pretty good amount of money, and you could have gotten a pretty good health center out of it.

But when this went to City Council, the City Councilmen and the community began to feel...where was this health center going, and we want health in our community. And this is the time that the City Planning Commission and the community went into the question of dividing the city up into ten districts, of two hundred thousand each...with the idea that eventually there would be a health center in each of these districts. And this was also developed just prior to the Clark administration, and was something which he had to work on.

And the City Council decided that rather than spend one or two million dollars on one health center, with the idea that maybe in another few years they would do another health center and so on, and eventually the ten districts would be covered, they decided that they would have a ....they would spend two hundred thousand dollars or so on a health center, and divide the same amount of money among the health districts in that way, so that the amount of money which was actually given to the Health Department...given to Rufus Reeves...given to me to develop a health center, was this amount of money, and the only
thing that you could do was to go out and get an old row house or something like that, and try and renovize it into something which would be a health center, which was virtually impossible. As I recall, there was only one health center on the drawing boards, the one that I can remember distinctly, is at 1408 Butler Street, which was a little row house just off of Broad and Erie. And shortly after Clark was in office, he came to the dedication of this center, which had been planned by the previous administration, and I can remember his disgust at seeing what anybody had spent any money for, in this particular set-up.

It was as a result of this type of exposure, I believe, or I'm almost certain, that Sawyer, who was or I guess, had been the executive of the Committee of Seventy, was it?

(WMP: He was the executive of the Bureau of Municipal Research. And then he moved over to be with the Greater Philadelphia Movement.)

He was the ..., and I'm certain that as a result of his work as executive secretary of that organization, that I had been exposed to him, so that after Dixon had been appointed, they were looking for someone in the Health Department, who had sufficient experience with the Health Department, and perhaps ... enough knowledge and could be trusted under the guidance of Dixon, to assist Dixon in putting his program into effect. And so, I mean, it was very simple. Shortly after Dixon had been appointed, and Buck Sawyer came through, we were still working in Denver) and he came through the inauguration, and while he was here, or just after he had left, Buck Sawyer called me over and asked me whether I would be willing to serve as the deputy health commissioner under Dixon.

(WMP: Had you happened to steer them to Dixon?)

No, I had nothing to do with that... nothing to do with that. I'm certain that Dixon was recruited through the membership of the Committee that Clark had advising him. Now one thing which I haven't mentioned is the fact that we haven't mentioned the need for any help about Clark and his campaign.

During the campaign, Clark .... And this was the first time it was done by any mayor, that I can recall (having been in the city government for quite a few years, for some twelve years prior) had ever campaigned on health. Clark had. One of the
things that he campaigned on was health and he appointed an advisory committee of physicians that was chaired by Francis Heed Adler and had a number of members. And they had a planks, as I recall, some ten missions. I don't remember in detail each of these missions, but I know that in general, they were patterned after the 1949 survey, which Clark had been familiar with.

The 1949 survey was jointly done by the Health and Welfare Council of Philadelphia and the City Planning Commission. It was conducted by the American Public Health Association as one of their functions and they assigned to it quite a good individual, Roscoe Kandle. And the United States Public Health Service epidemiologist and statistician by the name of Henry Goetz. Roscoe Kandle, just as an aside, to show his ability and prominence, subsequently became the health commissioner of New Jersey and for a number of years served in New Jersey as a health commissioner after he left as a Field Director consultant of the American Public Health Association.

Well this survey had some hundred and eighty or so points, issues, and so forth, which should be taken up, which you'd have to go to the survey to appreciate. But the planks which Clark had developed with the campaign on, were largely developed from the meat of this survey, and therefore they were on a good factual basis and presumably accepted by the community.

Well, this survey, by the way, was done in a somewhat democratic fashion, in that the individuals didn't just come in as experts and tell the community what should be done. After they had worked for some months, they had several days of meetings, in which individuals came together from throughout the city and from all of the important agencies of the city, and discussed their recommendations. And in general, these recommendations were acceptable to the informed health individuals in the community, and therefore were not only of good quality, from the public health standpoint, but capable of execution.

(WMP: How about the County Medical Society? Did they help as an organization?)

(Theodore Fetter M.D. represented the Phila. Co. Med. Soc. on the Executive Committee of the Survey, which had fifteen members.}

Well, the County Medical Society, with respect to this and to many aspects of the health program, have been what I call rather ambivalent. In general, they posture being in favor of good health and of doing what is necessary to have good health, but they are opposed to anything which would tend to support the payment of health care from any public source. And also opposed in general, the development of ambulatory health programs in health clinics unless the fees were very rigidly controlled and unless they were for poor people only. So that the County Medical Society was not a partner to a survey of this sort. But did not openly oppose it. Their attitude in general was...watch it...to see that it didn't get out of hand.
Mayor Clark was interested in all of his offices in getting the best quality and qualified individual that he could for the position. And as a matter of fact, one of the things that he stated and which, I believe, for the most part, he took very much to heart, was in having someone who was really competent to run a program, and qualified to run a program, without a great deal of outside consultative professional advice.

That's not to say that you didn't consult the community. What we're talking about is having an individual who knows enough about his subject from the technical and professional standpoint, to be an authority in his field. This is the type of individual which Clark tried to obtain for each of his positions.

He decided, on advice of his professional advisory committee in health, that there really was not in Philadelphia, at that time, any selection of qualified public health physicians. Philadelphia was not favored with having a public health school, as such, and having had a largely politically motivated public health program, they had not had the opportunity to develop or attract strong health professional personnel.

He therefore decided that for this position, as he did for some other positions, heads of departments, that he'd have to go outside the city. He selected Dr. James P. Dixon, who was at that time, a young man...I believe thirty-five years or less, of age, but who had already established something of a national recognition for progressive public health, particularly in what we would term, the medical care field, rather than the preventive medicine field. That is, Dixon's primary interest was in the delivery of medical care to people. And Dixon, realizing that many individuals in the country, for a variety of reasons, were denied ready access to health care, sometimes because of lack of funds, sometimes because of social or other conditions, that it was necessary for public officials and governments to take a somewhat aggressive point of view if the total population was to be adequately covered.

He also felt very strongly that the health department, as a public office, should guide, not necessarily furnish, but guide the program for total health care for the community.
This was very progressive for a city like Philadelphia, where most of the health policy in the past had been formulated by the Philadelphia County Medical Society, and where the health commissioner, in fact, was largely guided by fifteen or twenty... Philadelphia County Medical Society advisory committees.

Well, anyway, he came from Denver. Is that right?

(WMP: Quig Newton was the mayor of Denver and he was running a reform organization out there.)

Yeah. Well, I have no doubt that they probably recruited Dixon out there for the same reason... that Clark recruited him here. I mean, maybe Clark knew Quigley, I suppose...

(WMP: I think he got to know him later at the Mayors' Association... that sort of thing.)

Well, anyway, as Dixon's reputation preceded him to the city, and greatly disturbed the Philadelphia County Medical Society, certain of the leaders of the Philadelphia County Medical Society, decided that they would do everything they could to try to prevent Dixon from assuming an active role as health commissioner.

This was not done openly, but was done under cover. And I don't know of any open expression on the part of the Philadelphia County Medical Society against the appointment of Dixon. Dixon, being of military age, had never served in military service and therefore was subject to draft under the draft board. Coming to Philadelphia, he had to change his registration from Denver to Philadelphia. When he came to Philadelphia, the draft board in Philadelphia, I'm certain, stimulated by these physicians in the Philadelphia County Medical Society, called Dixon to active duty.

He went into military service about three months, as I recall, after his appointment sometime in March or April of 1952, and fortunately was appointed to the United States Public Health Service, and assigned by them to the Hoover Commission, and, as a matter of fact, used his time in the Public Health Service, very profitably, by studying many aspects of medical care on a national basis, a subject in which he was interested and somewhat expert. And I'm certain that this was valuable information also for him when he returned to Philadelphia.

Just as an aside, and while I'm...... as an added observation, while we're on this subject, and showing something of the progressiveness of Dixon in the medical care field, when he left Philadelphia... I believe it was in 1959... he had as one of his obligations to address the medical care section of the Pennsyl-
vania Public Health Association, which had just been formed that year, in other words, this was the first meeting of the Medical Care Section of the Public Health Association...at their annual state meeting at State College...this meeting was held in the middle of August, and Dixon left to assume his post as president of Antioch in the first of August. He therefore asked me to deliver this very detailed paper, expressing very clearly his ideas on the development of medical care in the United States.

And I agreed to do this, since there was not much for me to do as he gave me very elaborate notes...he didn't actually write the paper, but he gave very elaborate notes, so that I just really had to collect these notes and give the paper. The paper was acclaimed by all that heard it, as a very outstanding and forward-looking paper, and it was requested for publication by the Public Health Reports of the United States Public Health Service. The interesting thing was, however, that when the paper was submitted for publication, and went to their review board, they decided that it was so controversial, politically, that they would not accept it to the Journal. And eventually negotiations were made to publish it in the Journal of the American Public Health Association, where it is published under my name and not under Dixon's name. But I use this as an instance of how progressive and how forward-looking Dixon was, in terms of the type of program which we were developing in the city of Philadelphia.

June 26th, 1978 - Second Interview

I will proceed more or less with the questions outlined, although I have, in thinking over them, added a few things which are of interest to me. I think I will start out now with something about the conditions in the Health Department when Clark came into office.

I had been long enough in the Health Department, and had organized the division of Venereal Disease Control, so I knew pretty well what the ropes were. I'm not certain, since you've interviewed a number of other individuals in regard to the city government, whether the type of things which I have to say about the political influences and the way it operated, will be a duplication, but, if so, you can stop me at any time.

(WMP: You'll either be adding new material or you'll be contradicting or confirming.

Prior to the Clark administration and the recruitment of Dr. Dixon, they had had what would be considered essentially un-
qualified health commissioners and being unqualified and
being as health was not considered a strong political issue,
the health commissioner had very little political clout,
either.

At the time Clark came in, they had a specialized, a centralized program in the health department, which meant that there were a large number of individual units in actuality, there were some seventeen divisions responsible directly to the health director, so that there was really very little possibility of co-ordination, and as a matter of fact, it was really not possible to hold a staff meeting with such a large group. And in all the time I was in the health department, I don't think there were more than two or three attempts at a staff meeting, prior to 1952.

Interestingly enough, the health budget was really not prepared or presented by the health director. They had in the Health Department, as they have in many politically operated units, a long standing individual who works with the party around the head of the department. And in the health Department, this was William Wolf, who had the title of Secretary of the Board of Health. And I would not characterize him as anyone but a very competent type of individual for the type of job which he had to do. Interestingly enough, even though there was a secretary at the Board of Health, the Board of Health, as such, was more or less non-functional. And I don't know of any significant action it took in the ten years I was associated with the department, prior to ....

(WMP: You mean non-functional, rather than non-active?)

Well, I guess I really mean non-active. I guess it did perhaps have some functions to perform, in terms of regulation, but in actuality, really, it did not meet, and seldom took any action. Although the secretary of the board, this William Wolf, was, you might say, the backbone of the Health Department, and really controlled the budget, more or less controlled the appointments, was the principal liaison officer, really, between the mayor and the political community in general.

(WMP: Was he an M.D. or not?)

Oh no. No, no. He was...I don't know that he would...I would think that he would be a self-taught Republican administrator, of, I would say, considerable ability, but I'm not certain.... I'm certain that he had no qualifying degrees, either in health or in public administration. But he knew the ropes very well.
He had actually served in the Health Department continuously since just following World War I, so that he had had, at the time that I went with the Health Department, twenty years plus experience in the job that he was doing, and had gone through several administrations, and several health commissioners.

Now, in the Health Department, as I presume in the other departments, the weak mayor system was rather significant, in terms of the internal controls.

(WMP: That was under the 1919....)

That was under the old charter...under the old charter...a weak mayor system, and in actuality, even the budget, which the mayor submitted in those days, was not the budget which was adopted. It was called the mayor's budget and the mayor's budget was a starting point from which the City Council constructed a budget. The director of health, as such, had relatively little to do with the preparation of the budget, or the presentation of the budget. It was the line operators of the various divisions that dealt directly with the city council, and appeared before the City Council, and got programs or not, depending upon their political acumen.

(WMP: Do you remember Frank Short?)

Yes.

(WMP: Did he play an important role in the budget? Because he was really the key staff man on City Council, as I remember.)

Oh yes, I think that he was a very key individual because of the fact, that what was adopted eventually, was really the City Council's budget, based upon the changes which were made from the mayor's budget, which were usually very extensive.

Now another thing which we had then, which the charter did away with, was the line item budget, which was a very strict line item budget, to the extent that each position was categorized, and you couldn't move money out of any item to another item, or out of any item, without the presentation before City Council, and the action of City Council.

The ropes in setting up a program and getting appointments and in developing a program under this regime, were really very interesting. And I was rather fortunate when I went into the Health Department, of having as my guide, a rather seasoned individual, Martha Tracy, M.D., who had retired from the former deanship of Women's Medical College. And, as a matter of fact, she died in office, so to speak, and I would say, devoted the last years of her life, really, to quite a humanitarian service, considering
the type of program that had to be developed.

In the first place, professional political appointments... ...or professional appointments in those days had to be made politically. And this meant that not only... that the appointee had to fill out an application form which gave an opportunity to list credentials, but also required political sponsorship. And, of course, no self-respecting physician would really work full-time for the Health Department, that is place all their eggs in one basket, so to speak, or would really go through the political machine in order to get appointed.

It was possible, however, for me as division director to deal directly with the Central Republican Campaign Committee Headquarters. And I believe the Central Republican chairman at that time was a fellow by the name of Harris...

(WMP: Dave Harris.)

Dave Harris. Yeah. And many is the time that I personally went to Dave Harris with my medical appointment, gave him the sheet....he, in turn, would go to the back room and call up the political ward leader, explain the necessity of making the appointment and himself endorse the appointment. I think that perhaps this worked a little better in my unit than it would in some. First of all, because it was during the war effort, and secondly, because there was perhaps less opportunity for political machinations in terms of a health program dealing with venereal disease than there was with other programs, such as environmental health or hospital admissions or something else, for example.

I don't think at that time there were any physicians working full-time for the Health Department with the exception of someone like the superintendent of the Philadelphia General Hospital. And, although it was not in the Health Department, someone like Wadsworth, the coroner, who, I believe, but of course, the head of Philadelphia General Hospital in those days, and I guess almost anytime in its existence, was a very...you might say...I don't know what to say...a very lucrative, but it was a rewarding and attractive position, and carried...what in those days was a high salary...I think about $8,000 a year. And in addition to that, however, complete maintenance. That is, complete living facilities.

(WMP: Wasn't there a man who later went up to the Einstein Medical Center?)

Yes. At the time that the Clark administration took over, Pascal Lucchesi was the superintendent and medical director of the Philadelphia General Hospital...that was the title.
He was preceded by William G. Turnbull, who had followed Doane, I guess. Doane was really responsible for the commencement of the revitalization of the Philadelphia General Hospital in the 1929...'30...along that area. Turnbull had been at the head of the hospital up until about 1943; he was followed by less than a year by his medical director, a fellow by the name of Hneleski. And then Lucchesi took over and was medical director up until 1952, when he left to go to Einstein Northern.

(WMP: How did Tina Weintraub get to be the ....sort of the manager of the Philadelphia General Hospital?)

Well, of course, this really followed her long career in city government. She came into the city government, as you know, as a deputy managing director. And from very early in the Clark administration and under Buck Sawyer, she was assigned to the Health Department. So that she was the individual in the managing director's office that the Health Commissioner answered to, and communicated with, in terms of health matters. She maintained that position during the next ten or fifteen years, and when they had increasing difficulty in turnovers in recruiting adequate individuals for the Philadelphia General Hospital, having up, until that time, always had a medical director....the board of trustees of the Philadelphia General Hospital, which is responsible for the recruitment of the head of the hospital, Pearloff was then the chairman, decided that it would be very appropriate that they recruit a public administrator, as head of the hospital, rather than a physician, as possibly being a better qualified individual to run a public institution....so that was the way in which Tina Weintraub became ....

(WMP: Had she been looking into it through the managing director's office before that?)

Well, yes. I mean....she...see, the Philadelphia General Hospital is a part of the Health Department. And so that she was just as much supervising the general management of the activities of the Philadelphia General Hospital as she was the Health Department as a whole.

(WMP: Well, as I remember she gave special attention to the hospital.)

Well, I mean she......I mean, I'm not convinced that she gave any more attention to the hospital than she did to the Health Department, but it was one of her functions and one of her....
that she took her responsibilities very seriously. And she knew a lot about the Philadelphia General Hospital, of course, before she went there.

(BF: I think that sort of jumped way ahead)

Now, I think I'll proceed with...first of all, the...some of the general improvements in public administration that came in with the Clark administration in the Health Department. And in fact, most of these, or many of these, are really inherent in the charter, basically, I would say. The charter gave a type of framework which was not available to the Health Department. The first thing is that it really required the qualified personnel. The charter not only provided for a Board of Health, but indicated the type of individuals who should be members of the Board of Health... and also provided specifically that there be in the Board of Health physicians and at least one qualified professionally and through educational background in Public Health.

(WMP: Did you have a hand in preparing those provisions?)

In suggesting the individuals to be members of the Board of Health?

(WMP: Well, that and also the set-up...the changes that were made by the charter.)

Oh, well, I don't know that I played any significant role, but, it is true that not very many individuals in the old Health Department were interested in the development of the new charter. But they had been asked to participate. And the then director of health, Rufus Reeves, because of my general interest in the district health program and other matters in the Health Department, had designated me to work with the charter group in relation to the new city charter. But I was I guess, more cognizant of what was going on than myself playing a too significant role in the actual development of the detail of the charter, so far as it pertained to the Health Department, and many of these aspects, of course, were rather general in the charter, and applied not only to the Health Department, but really to all the departments of the city government. So that I think that in this and to this extent, the Health Department benefitted along with the city government as a whole, and the...and it wasn't particularly singled out in any way, in the charter.

(WMP: Well, at some point, I don't know if it comes in here, will you tell us about how it worked out in practice, the new provisions of the charter?)
Yeah. Well, I have a few comments to make at this time with respect to the way in which the charter did affect the Health Department.

First of all, with the managing director, we, for the first time, had a means of communicating among departments of the city government. In addition to that, of course, the charter did many things to streamline the city government, which affected the Health Department, and made a different Health Department in Philadelphia than in most other large cities, in terms of its responsibilities.

One aspect of this, of course, had to do with the licensing and inspection function, in which the Health Department set the general standards for health, but in which the actual enforcement of these regulations, particularly in the housing and many of the other environmental areas, and in the licensing area, was handled by another department.

(WMP: It's called Licenses and Inspection, wasn't it?)

The Department of Licenses and Inspection, yeah.

Another thing which I think was rather significant, and really supplemented the charter, was the desire on the part of the city government, that is, both the mayor and the managing director, to obtain and to actually train their top level government personnel, so that the Health Department, as was true of the other units of the city government, were offered the opportunity to go to the Fels Institute of Local and State Government, and a number of individuals in the Health Department did avail themselves of this opportunity, and several of them actually completed the certificate course and two or three of them got their degrees in public administration at the Fels Institute, as a result of this opportunity.

(WMP: Do you think that benefited the department greatly?)

Oh, there is absolutely no question that the ability of the department, in general, to deal with public matters, that is to deal with the public and the community generally, and to deal, particularly with the City Council, and not only that, the other governmental agencies...the state government and the national government....was greatly enhanced by that type of experience.

That type of experience is not available in this way to professional public health personnel. They do have something they call public health administration, which is taught in schools of public health. But it does not have anywhere near the broad aspect that you get through something like... an institute of local and state government.
And I think that that was really a great value.

Another thing which the charter did to affect the total health delivery system in Philadelphia, was the way in which the Board of Health related to the Board of Trustees of the Philadelphia General Hospital, and you might say, also the real recognition by the city administration, and I guess, particularly the mayor, of the significance of this relationship. In most large health jurisdictions, the health department is not concerned with medical care. It's concerned with preventive medicine, and with environmental health and although many large jurisdictions do have, and have had public hospitals, the public hospitals have usually come under a separate unit, outside of the health department, such as a bureau of hospitals or of institutions and agencies.

(Tape was changed at this point...a few words lost...)

It really was not possible, therefore, for preventive medicine and ambulatory medical care and emergency medical care and what-not, to co-ordinate with a long term illness, such as mental health and retardation problems, the aging, bedcare generally. And the way in which the charter was set up under the Health Department, assigning to the Philadelphia General Hospital and its board of trustees, the day to day operation of the hospital, and to the Health Department the determination of the type of patients to be admitted to the hospital, and, even the number of beds that were to be maintained at the hospital, made it so that the Health Department had a very direct influence on the total medical care program of the community, particularly when the Philadelphia General Hospital was in existence, and had a very large population.

The mayor recognized the importance of this liaison by interlocking the boards, so that there were three members of the Board of Health who were also members of the board of trustees of the Philadelphia General Hospital. This is required on the part of the health commissioner, who is the president of the Board of Health, and also is required to be a member of the board of trustees of the Philadelphia General Hospital. But in addition to that, the mayor appointed to both boards, George Clark, and he also appointed a woman by the name of Riemer....I regret I don't remember her first name, but she was a rather interested and experienced in the volunteer health field in the city.

One interesting aspect of this is as the time went on, because of some of the problems which developed at the Philadelphia General Hospital, in particular, during the Clark administra-
tion, there were so many meetings of the board of trustees of the Philadelphia General Hospital, in addition to the regular monthly meetings of the Board of Health, that it became an impossibility for these individuals who served on both boards, to really function in both of these capacities, so that interlocking was discontinued after the first administration.

And unfortunately, because of that, even though there was still the liaison provided by the health commissioner, the program of the institutions tended to drift apart, until, in the mid-1960s...about 1966..1967....with the increase in prominence of the federal Medicare-Medicaid programs, and health planning programs, the need for some liaison became apparent, and rather than have interlocking members, the boards met jointly periodically, I think about quarterly the Board of Health and board of trustees of the Philadelphia General Hospital held joint meetings in an effort to bring that about again, and that was.....

(WMP: May I inject one more question? What about mental health?)

Well, the Philadelphia...that is, the new administration...I think probably...principally Dr. Dixon, although this is not specifically stated in the City Charter, felt that mental health was an important public health program to be represented. And so, he set up a division of mental health very early in the Clark administration. And as I recall, the first director of the division of mental health, Dr. Morris Linden, was recruited about 1954.

One of the real problems which faced all communities in those days, including Philadelphia, was the problem of having facilities to care for..."long-term mental illness." And the city of Philadelphia had in prior years, I guess in 1937 or '38, turned over its long-term mental health facilities to the state. In other words, Byberry, became the Philadelphia State Hospital at Byberry.

(WMP: What year was that again?)

I think it was around 1937 or 1938. It was prior to the Clark administration, that this function was turned over by the city to the state or the state agreed to assume this function.

This made it, however, so that patients were diagnosed with mental health problems, in Philadelphia, and this was done...
largely at the Philadelphia General Hospital, because very few general hospitals cared for mental patients in those days, the facilities at the Philadelphia General Hospital were greatly over-taxed. I believe that the so-called Stauffer Building, which is a large unit at the Philadelphia General Hospital, containing some capacity for 200 or 250 beds, became crowded enough to have 400 to 500 patients in that facility, with inability to get them out of the facility, so that the patients accumulated not only in the hospital, but also in the jails, and other places.

And one of the things which Linden devoted himself to, one of the principal things he devoted himself to, early, in his administration, was liaison with the state, in order to get a better passage of patients back and forth between the city and state. And this, in time, tended to relieve the situation.

Linden also endeavored to develop what might called preventive mental health services and educational services. He conducted clinics and saw patients, but you recall that this was before the national mental health and mental retardation program, and I think that really, aside from the type of thing that I discuss now, the mental health program in the Health Department accomplished very little in the community as a whole, in terms of the control of mental illness, until the national program went into effect.

But, Philadelphia, having had a running start, so to speak, was one of the first units in the country to benefit from the mental health and mental retardation funds which began to become available in about 1967, I guess, and developed a large mental health and mental retardation program, financed in major part through the federal funds which were administered through the state, and matched in general, by the state. So that this program in the Health Department, which I presume, started with three or four hundred thousand dollars, has become, just in terms of dollars, a twenty to twenty-five million dollar program at the present time.

(WMP: Just in Philadelphia?)

Yes. Just in Philadelphia. And this is one of the ... I would say, all of this, really, is a continuation of what was started in 1954, but of course, the national program has made it possible for many or most localities to develop similar types of programs.
You'll find, however, I think, if you study most of the large cities and states, that there are very few in which this program is co-ordinated with the other health programs within the health department. They usually have a separate unit for mental health and mental retardation, which again, I don't know that it's ... I think it is, to some extent, significant, because the closer you keep the diseases together, which require hospitalization, and medical care, the easier it is to make full use of the economies and efficiency of program development.

Another... this may seem like a somewhat minor thing, but I think has some significance, and had to do with the way of handling special funds, in relation to the charter.

Prior to the city charter, it was possible to go before City Council and request the setting up of a special fund to handle monies which might be obtained from other sources, such as governmental sources. Since venereal disease control and tuberculosis control were two of the programs which first began to receive a substantial amount of federal funds, first the venereal disease division and then the tuberculosis division went before the City Council and requested, I think... as I recall, they were called 3S funds... I mean, this is just a name of the account, which was set up in City Council.

The reason for setting them up in special funds was ostensibly for accounting purposes, because the funds being received from the federal government had to be accounted for to the federal government, and it was easier to account them if they were in a special account in which all the input and output was related to that, rather than to a general fund.

This made it possible to build up very substantial amounts of money in special funds, because, for the most part, in the city government, what the special funds were given for could be paid for out of the general fund budget. For example: one of the programs which the federal government gave substantial amounts of federal funds, was for continuous intravenous drip for the treatment of syphilis. This was a program requiring several days of hospitalization of each patient that received the treatment. This, of course, treating in the course of a year, hundreds of patients, resulted in a substantial amount of money. So that hundreds of thousands of dollars were going in this special fund, and the special fund remained under the administrative control of the head of the institution to which the funds were granted. So that these funds, once the program was carried out, I mean, the patient had to be hospitalized and had to be treated, but the government had no desire to control the funds after the service had been provided. And it was possible in that way, to get funds which could be utilized to develop specialized programs, not actually funded by the city.
the City Charter did away with specialized funds, so that this method of handling governmental funds, and you might say, re-using them, was done away with by the City Charter. And all of the very large amounts of health funds which go into the city program now, go into the general fund and partially finance the budget. And this is taken into account in the budget presentation. I mean, they usually budget so much of this is going to be received from the federal government—

There are two what I would call rather significant exceptions to this, even up to the present time, or practically to the present time. One had to do with the combination agency which was formed for public health nursing, in which the program was set up so that the voluntary agency part of the combination agency, which was composed of, initially, the Visiting Nurse Society of Philadelphia, and the Philadelphia Department of Public Health Nursing Unit, took over the handling of any funds which were collected.

(WMP: About when did that occur?)

Well, the combination agency was envisioned very early in the Clark administration in 1953, 1954. But didn't actually go into effect until about 1960. And I can discuss that separately if there's more interest in that, but I'm more interested in the special fund situation, for the moment.

This made it possible for funds to be collected by, and deposited in the voluntary agency, from patients in health centers or patients in the home, for home visits. It also made possible, when Medicare and Medicaid came into effect, for rather large amounts of money, which now reach into the millions of dollars, that is, over a million ... what I say millions, I don't mean ten or twenty million, but it is ... I'm sure between a million and two million dollars is collected through these types of funds, and goes into the account administered by the voluntary agency portion of the combination nursing agencies.

So that these funds can go directly into the program without being appropriated through City Council and partially be re-used again.

Another instance of this, which made it possible for the city along with some of the physicians at the Philadelphia General Hospital who were closely associated with the medical schools, and in teaching and research positions, to accomplish the same type of thing, was with what was set up as the Philadelphia General Hospital Research Fund. The board of trustees of the Philadelphia General Hospital early in the Clark administration and the principal motivators of this were Frederick Mann, who was on that board and also city representative at the time, and Patterson, who was a member of the ......
John Patterson. Those were the individuals who were principally behind the concept of doing this. As a matter of fact, interestingly enough, as acting health commissioner at the time, I was, from the standpoint of a public health administration purist, opposed to doing this; but as time went on, I saw the merit of doing this.

They set up...they, first of all, incorporated the Philadelphia General Hospital Research Fund which made it possible to receive funds, and this resulted in expenditures of well over half a million dollars, and in some instances, I think pretty close to...I'm not as much as a million dollars a year, which were spent in rather significant research programs at the Philadelphia General Hospital. So I thought that was a kind of an interesting aside. Much of the cost of staffing and hospital care for patients for these research programs came out of the City general fund, so that the grant funds could be reused to expand the research program. The...Now the departmental organization which the new health commissioner was responsible for, and in applying the charter, I think was rather significant in terms of the type of programs which were developed and the way in which the department was organized...I've already remarked on the fact that it was not possible to coordinate the functions of the preceding health departments because of the large numbers of units which made it impossible to even hold staff meetings.

Exactly the opposite was true under the new administration and they determined very carefully, to keep the span of supervision such as to make it possible to work almost initially, on a one-to-one basis. There were two deputies, under the health commissioner; each had rather clearly defined responsibilities.

The so-called first deputy...he was called the program deputy...and he was in charge of health program development and also in charge of the professional health services...such as would be provided by physicians and nurses, in the district health program.

And the second deputy was an administrative deputy, so trained, it was Owen B. Stubben, initially, and he was given the responsibility to do the general administration of the department; in other words, to determine the personnel practices, to develop the budget, and he was also assigned those elements which dealt more particularly with business in the community, in terms of the capital program, and in terms also of environmental health and.....including air management.
The next thing that was necessary to do was...in order to do away with these multitude of individual units, was to develop a generalized, de-centralized program, rather than a centralized, specialized program. And this required a tremendous amount of re-training within the department, so that for the first year or two, the re-training programs were very substantial, although having started early in the administration...

(WMP: This is the Clark administration still?)

Oh yeah. This is the Clark administration...early in the Clark administration...we had to re-train all of the nurses. And we had an individual...Eleanor Lefsen, was her name.... who did the in-service training for the public health nurses, in which nurses who had only venereal disease control or who had only done tuberculosis control or only done maternal and child health, or only occupational health, or only home visiting, and so forth and so on, where each of these nurses were trained to do each of these things. And trained not only to work in clinics, but also to work in the field and in home care.

And in the first year or year and a half, there were approximately a hundred or a hundred and fifty nurses who were re-trained in this way.

The problem was just as great or even greater for the various types of individuals who had been assigned to the Health Department, which had been assigned to the Health Department in environmental health, and some of which had been taken over by Licenses and Inspections. I mean, the Health Department was responsible for plumbing inspection, for housing inspection, restaurant inspection, food processing, meat, and all that type of thing. And each of those were individual units in the old Health Department...each with its own division director and each with its separate staff. And it was necessary to, in some instances, to detach this staff from the Health Department, to go to the Department of Licences and Inspections, and in other instances, to re-train, insofar as it was possible to re-train, the individuals in the Health Department to perform all of these functions...and then in addition, since many more individuals were needed, to recruit public health sanitarians to cover this entire field.

This area, as might be surmised, was one of the most political areas that you could imagine....because all business interests, small business interests, individuals with special interests, would approach their councilmen, and whatnot, in order to get a license, whether they needed it or not, or to have the regulations altered or overlooked...
and what-not.

(WMP: Of what period are you speaking now?)

Well, this is again, prior to the Clark administration. This is the way it was set up. And the thing which the new charter required, really, and all that Clark and Dixon and Stetson did, was to develop the administrative methods under the new charter, to change this group of largely politically motivated individuals, to an organization which responded to health standards and health regulations.

I would just like to ..... well, Another area, since we're talking about political influence, which has been remarked about, although as often denied, has to do with the political influence in relation to building and architectural contracts.

And there is no question that, prior to the reform administration under Clark, that in order to receive architectural contracts, for construction, for example, it was necessary to make political contributions to the party. And I guess you could perhaps look at it in another way....by indicating that political contributions were not required, but that the architects that had made political contributions were selected from among those who did make contributions. So that I think.. ...I mean, this is something that has been bandied about a good deal.

Well, this being known to be the case, the.....for the first health center, which it was planned for the Clark administration to construct....and we're now talking along in 1953 or 1954....they decided to do away with the possibility of awarding on any type of political basis, by having an architectural competition. So that competition was invited, and the judging was done...I don't remember everybody....that is, several individuals were selected to assist in the judging; I'm certain that among those were the city architect and the managing director. But in addition to that they had other individuals outside of the city government to assist in the selection.

And they had a number of individuals compete; they were surprised at how many there would be....I don't remember exactly how many....but they had at least fifteen or twenty designs submitted for a district health center. And I'm certain that the selection was made on the basis of the design alone. I mean the real... and there was....The design that was selected was considered to be a very creative design, both from the standpoint of the operation, that is the planned operation of the health center
and also from the standpoint of the architectural construction.

So far as the health center itself was concerned, it had a flow-through pattern for the entire health center, which was something which was new to the Health Department at that time.

(WMP: This was for each health center?)

Well, this is for a district...one district health center to cost...you know...$900,000 or $1,000,000 to serve a population of some two hundred thousand people. And this happened to be for the health center which was constructed and still exists at 415 Girard Avenue.

(WMP: This was the first one?)

The first one. Yeah. The first one. And ... It was very difficult, since the Health Department had, in the past, dealt with specialized programs, to get anyone in the Health Department to think differently than having this section of the building for a tuberculosis clinic and this section of the building for a child health clinic, and so on and so forth...and having them all combined in the building, so that they could go back and forth.

But it was very difficult to get them to think of examining things for individuals to flow through having all types of service, you see, and for these individuals....

So this was the innovation that this architect made which was new to the Health Department and new to the city government, so far as flow was concerned.

In addition to that, in order to make the best utilization of the ground, this was; I believe, the first building that the city architect had accepted, and supervised the construction of, with a cantilever type of overhang, in order to make maximum use of the plot and what-not. It had the entrance overhung considerably, and the second floor, which consisted of a lot of the clinical facilities and what-not, was out over this overhang, and had to have...you know central hanging, cantilever construction to do this, and I believe that I'm correct in saying...this was the first time that the city architect had entered into this type of construction.

Well the interesting thing was that the individual who won this competition was quite a young architect, and...
less unknown architect, from the standpoint of the community.

It so happened that when the construction was about half through, he got into sufficient financial difficulty so that another architect had to be appointed to assist him out of his financial difficulty.

It also so happened that the cantilever construction aspect of the building was so poorly designed and developed, that almost before the building was in operation, the floor began to sag on the second floor, and it was necessary to construct pillars up each corner of this building to hold up the center.

So this, in a sense, gives both sides of the picture. That is the last time that the Health Department used competition...and I'm not saying that this wasn't a very forward-looking building...and has been very useful....but through having a competition there was this type of problem.

(WMP: Was the name of the architect Pope, by any chance?)

Well.....I wouldn't like to say....it could be looked up without too much difficulty....

(WMP: I'm just curious...)

He was a young, conscientious architect. I mean, I don't think there was anything....I mean I don't think there was.....I'm convinced that there was no wrong-doing, as a result of this.....it was just that he was.....it was very forward-looking, and in general...the health centers that were built subsequently, were not dissimilar, in terms of flow-through patterns, and you know, getting away from the specialized programs within....layout.

Now, I think we could, if you want me to, talk a little bit about some specific programs that were developed in the early part of the Clark administration, and developed in subsequent years, through the Dilworth administration and up to the present time.

I think the....one of the most significant programs which was developed, was the one which we have referred to previously, as being a part of the 1949 health survey recommendation to develop a de-centralized, generalized district health program.

The initial steps to accomplish this, had been started by the Health Committee of the City Planning Commission, just prior to the time that Clark came in. This health committee was chaired by Rufus Ror().
the hospital council then, but he was a nationally known expert in hospital administration and hospital program development, and served as consultant in that field for many years, even after he left the hospital council of Philadelphia.

And he was a very responsible individual, in terms of recommendations and developing his program, and I'm certain, had an important role in the 1949 health survey as one of the community individuals interested in health program development.

They developed the concept of grouping the census tracts into ten health districts of approximately two hundred thousand individuals each. The concept was to develop a physical facility in each of these locations which would essentially de-centralize the program under general overall supervision. They envisioned having a district health officer who initially was thought of as being a well qualified public health physician...a group of generalized public health nurses...and so forth...the idea being that these individuals could develop programs which suited the community. And if you look over any large city, including Philadelphia, you will find that the health needs of one community...one part of Philadelphia...are very much different than the health needs of another, both in terms of type of service, and in all aspects of the program.

At the start of the Clark administration

Another fundamental...so that this much, really, had been accomplished, and that's about all that had been accomplished, other than the idea that there should be health centers, and as I think I indicated last time, that there was money given to develop store front health centers, the renovation to cost two or three hundred thousand dollars per health center, in each of these districts, which was immediately abandoned as completely unsuitable by the new administration.

Now, the idea of these programs in the health district, as approved by the Board of Health, early in its

(WMP: Dr. Hubbard?)

Yeah, Dr. Hubbard...he at that time was professor of Public Health at the University of Pennsylvania...of course he's, at present, the president of the College of Physicians, in years labor, but...College of Physicians of Philadelphia.
But he was chairman of a committee that accepted the district health concept as had been prepared by the health committee of the City Planning Commission, and more or less the policy of going ahead.

Previous health program had been confined largely to preventive health services...such as childhood immunizations, such as syphilis contact tracing, tuberculosis control and so forth...but they definitely agreed that a part of the Health Center should be ambulatory care services, in the broad sense.

They also agreed that the Health Center would not be limited to any segment of the population, but that it should be equally available to all individuals...doing away with the concept of that the Health Department provided services only for the poor or the needy. But that it was just as important in a district health program to have the services geared to anyone who wanted to apply to the service, so that no one would be turned away from the Health Service.

(WMP: Was there any resistance to that by the medical leaders?)

Well, the medical leaders in general resisted this, but had no particular influence on the administration or on the development of the program...although, for a variety of reasons, as...as much as anything dealing with staffing and funding, the program developed very slowly. In general, the concept of having ambulatory care given in health centers, initially, was opposed by organized medicine, especially the Philadelphia County Medical Society. But, for reasons which will become apparent in some of the things I'll discuss later, it became gradually more accepted through liaison with the medical schools, and through staffing of the health centers through individuals provided by other institutions, so to speak. So that this was the one way of getting around even that type of objection.

No fee schedule at that time had been established, no funds were collected in the health centers, but it was thought from the start, that depending upon what developed, that it would probably be possible...or probably be necessary to develop some type of a cost program. Of course, at that time at the Philadelphia General Hospital, did run an out-patient department, and did collect fees in accordance with the ability...the person's ability to pay...but based upon the type of experience they had had at the Philadelphia General Hospital even then...and this is back in 1952, for...in the neighborhood of three or four hundred thousand visits a year, the total collections from the out-patient department would be in the magnitude of twenty-five or thirty thousand dollars, so that they didn't really collect very much, even though the individuals did pay in accordance with their ability.
(WMP: Do I interrupt your thoughts sometime by asking too many questions?)

No. Go ahead.

(WMP: I'm curious about the role that Charles Frazier may have played in re-organizing the Philadelphia General Hospital.)

Well, Frazier was chairman of the Board of Trustees during a good bit of the progressive development. Of course, the first chairman of the Board of Trustees was Scattergood, who had been....

(WMP: Alfred Scattergood?)

Alfred Scattergood...who had been, I guess the president of the trustees and maybe still was of the Pennsylvania Hospital, and a very well respected individual.

At the Philadelphia General Hospital, the largest crisis that developed at any time during the administration, had to do with the relationship of the hospital to the teaching institutions. And the Dixon and the Clark administration, generally, developed the attitude that....it was really not possible to recruit a larger set of physicians at that time at the Philadelphia General Hospital, other than the Medical Director and the...well, very few full-time...like the head of the laboratory and so forth...the head of the X-ray department....were without compensation....they were volunteer jobs. And they felt that it was impossible to develop and continue an adequate service program, with that type of personnel, and, as a matter of fact, everyone would admit that with the gradual changes in medical practice, that it was becoming increasingly difficult to get well qualified physicians to serve, free of charge.

Most of the physicians there, but not all of them, were affiliated with one or another of the medical schools in town. But they were not appointed by the medical schools. And it was proposed by Dixon and by Groeschel, who had been recruited by the board and with Dixon from the New York Hospital system, to have the medical schools staff the hospitals, and if necessary, to assist the medical schools in the payment of physicians for this purpose.

And this plan became known in the medical staff as the so-called "vertical service plan", that is five services from each of five medical schools and so forth and so on, and they very
vigorously opposed it as doing away with their rights to organize and run the hospital.

A part of the problem was, I guess, medical politics, in that it was possible for a physician who had been passed over or denied appointment in a medical school, to go to the Philadelphia General Hospital and become appointed.

(WMP: To become what?)

...and be appointed. And it was also, since the schools did not oppose the appointment, optional on the part of the physician that worked in the hospital, as to what he did so far as medical student teaching is concerned. So that, here would be physician-teachers of medical students at the Philadelphia General Hospital, whom the medical school would not have any say as to their appointment, in relation to the Philadelphia General Hospital, you see.

And this made it so that very awkward things occurred at times, such as, an individual would resign from the medical school staff, or would resign from the Philadelphia General Hospital, being an active teaching individual, say, in internal medicine, for a medical school, such as Jefferson Medical College, or Hahnemann Medical College, and the individual that's appointed in his place, would be from another medical school, or not medical school affiliated, and not interested at all in teaching those students, or would be teaching students from another medical school, instead.

So there was this type of problem which made it so that the teaching institutions in Philadelphia were very much interested in the possibility of contracting with the city to supply the medical services for the Philadelphia General Hospital, which in turn, would make it possible for the school concerned to control this teaching resource. And this is one of the crises which I...or the principal crises which I referred to when Scattergood was chairman...that made it so that the board met so frequently, two or three times a week, in order to try to solve some of these problems.

This also...I'm sorry that I can't give exact reference for this, but it could be looked up...the Philadelphia General Hospital controversy received national attention and was considered of sufficient importance and classic, but what at least one, and maybe two schools of government administration made a detailed study of this and published on the subject, using it as teaching material in government administration.

(WMP: Did they illustrate what shouldn't be done or what should be done?)
Well, I don't know! That's a very good question. When I used to teach at the Fels Institute of Local and State Government, they indicated that they were not interested in whether what you did was right or wrong, but that you did it and how you did it. And I think that is what these individuals were also interested in...in what occurred under certain circumstances and what the board of trustees did and what the mayor said and what the health commissioner said, and so forth.

Well, this actually resulted in a very strong conflict within the board. So that there was almost an even split in the board each time as to those who were in favor of vertical services and those who were opposed to it in general. The labor individuals on the board were opposed to vertical services and the medical and others were in favor of it, and this resulted in...at the end of the Clark administration...in a re-structuring, to some extent, of the board...one of the labor individuals, I think it was Schwartz, was dropped. For a considerable amount of time, they refused to name another labor individual to be appointed to the board, so the feeling was so bitter.

(WMP: Was that Joe Schwartz?)

Joe Schwartz I think it was. He was a member of the board and, as a matter of fact, was dropped from the board at the end of...when he came up for re-appointment, whichever it was. And for a considerable period of time, he was not replaced.

Well, this also resulted in the loss of Groeschel to the program. This individual had been recruited and was a good hospital administrator and, while this controversy was going on, of course, he was trying to put into effect the program which the administration wanted...I think he favored it. He asked for a vote of confidence on the board....I guess in about August of 1953, or maybe it was 1954....my mind isn't exactly clear on some of these dates, but I know that it was in the summer of that year...and the board failed to give him a vote of confidence. In other words, he could not yet sufficient to get...and Scattergood, being a good Quaker, more or less always dealt by consensus...and one of the reasons for the length of these meetings oftentimes, there was the fact that if there was any one disagreement, that the meeting could not come to an end until there was a consensus.

Well, Groeschel forthwith...I think it was in December, left the hospital summarily, with one day's or one week's notice, or some such thing as that. That greatly disturbed everybody, including the mayor. Groeschel returned to the New York Hospital System where he continued to serve with distinction for a number of years. Well, it was then, it was at that time...
With talking about Frazier, that Frazier, I believe at that
time, was appointed to the board and remained chairman of
the board for a number of years, through the Dilworth adminis­
tration, and did develop what was called the vertical serv­
ice which was actually a contractual program with the medical
schools to perform medical service at the Philadelphia General
Hospital, and through various evolutions...I mean it
started out with five medical schools. It proved to be not
too practical with five medical schools, since some were far
removed, some required less service than others and they dropped
it to three medical schools, and so forth, so it went through
various evolutions. And in view of the fact that the Philadel­
phia General Hospital itself is no longer in existence, except
for historic value....I don't know exactly what all this means,
at the present time.

(WMP: Well, what really caused it to go out of existence?)

Well, I think it might be well to consider that in terms of
really what happened, in terms of the medical care program
and what-not, and if we...which I'll go into, later.

I think I'll try and cover things a little more succintly,
and faster now.

One of the very interesting things which was developed some­
what uniquely, (at least Philadelphia was the largest city in
the country that had it, at the time it was developed)...It I
guess perhaps ever had it)...was so-called "combination nur­
sing agency". One of the things that the 1949 survey recom­
mended was that all of the nursing programs in the city of
Philadelphia be combined, and that they be served by general­
ized public health nurses.

By this, they were talking about the several voluntary agen­
cies which were in existence at that time....there were nurses
at the Babies' Hospital, there were nurses at Fife-Hamill Mem­
orial Health Center, there were nurses at the Starr Center in
Germantown, there was a very large voluntary nursing agency of
which Ruth Hubbard was the director for many years...the Visit­
ing Nurse Society of Philadelphia. And then there was the
nurses of the Philadelphia Department of Public Health and the
school nurses.

And the recommendation was that all these nursing agencies be
combined into a single agency.

It wasn't clear from the report, how this was to be done. That
is, whether the Health Department was to take over all these
programs and employ these nurses or how. But there had been
demonstration programs in parts of the country and particularly in Seattle, Washington, which was used as the model for the Philadelphia program.

Ruth Hubbard, who was the head of the Visiting Nurse Society, very early in the Clark administration, came before the Board of Health, and specifically presented the proposition of developing in Philadelphia a so-called "combination agency".

Now a combination agency, as it had been in Seattle, consisted of a formal agreement whereby the voluntary nursing agencies and the official nursing agencies agreed to function under an overall umbrella...the voluntary nurses doing the work which they normally do and the official agency nurses doing the work which they normally do...and then re-training the nurses within this unit, so that they can be inter-changed. And, in general, this would mean that they would, from this union, become, through re-training, generalized nurses serving the total community.

Mrs. Riemer, the member of the Board of Health that I already mentioned, was designated on the Board of Health the individual to try to develop this. She went along with me to talk with William Walker, who was vice-president of one of the banks, and who ...

(WMP: First Pennsylvania Bank.)

..First Pennsylvania Bank...and was rather prominent in health matters in the city. I mean, he had been associated with the Health and Welfare Council and in various roles, and we asked him whether he would chair a committee to study the possibility and work out a combination agency. And he agreed to do this.

But the problem was a lot more difficult and time consuming than anybody had thought at the time. In the first place, Ruth Hubbard, who I guess was really the principal inspiration behind it, unfortunately died shortly after this... I don't remember exactly what year she died, but before there was any possibility of developing the organization, she was no longer in the picture.

There was not a strong leader in the voluntary nursing agency group. And this left the board a little bit under a certain amount of confusion, because the Health Department had a rather strong personality in Madelyn Hall, as the head of their nursing organization, and re-training their nurses, and it was very evident to them, that if she was made the head of the organization, that the official agency would dominate
the situation. And they were not certain that they wanted to get into that type of a situation.

I think that that was...you know, only one of a number of factors which required not months, but years of study and negotiation, so that this was really not put into effect until 1959 or 1960, but did go into effect at that time, and has proved a very satisfactory situation over the years, although I'm not certain that the Health Department ever got out of it what it originally envisioned. As a matter of fact, the Health Department originally envisioned that public health nursing was primarily a local public health function, and that it would be nice to encourage voluntary agency funds to go into the program as long as possible, so that they were interested in having the visiting nurse receive funds through United Fund, and that, as long as the United Fund was willing to support such programs. But there's no question in my mind that all of the individuals in the Health Department, including the health commissioner, including the head of the district health program, including Tina Weintraub as managing director of health and what-not...that eventually it would be necessary for the city to take over this total program.

I don't think this was ever the thought on the part of the voluntary agency.

Interestingly enough, also, just as an aside, when these programs went into effect, both in Seattle and in Philadelphia, they were definitely considered to be experimental, and there was an escape clause, so that, if after a period of time...I forget whether it was two years or three years...it was a good trial period....either agency could withdraw...you know, upon will, so to speak. And in fact...either agency could withdraw...you know, upon will, so to speak. And in fact...either agency could withdraw.

And in Seattle, interestingly enough, and I didn't know this until rather recently...they very shortly after it was set up in Philadelphia, dissolved their agency. But in Philadelphia the agency is still in existence and, as a matter of fact, one of the reasons that I was aware that it was no longer in existence in Seattle, was the fact that the organization has been re-studying itself recently, as to whether it was accomplishing its mission and as to whether it should change or not, whether it should dissolve now or not, and we found out at that time, ...this is in Philadelphia...and we found out at that time, that the Seattle program, after which it was patterned, was...had been considered not too successful and had dissolved in 1962 or '63, or something like that.
As an indication of the very strong support that the Clark administration gave to nursing, as to all health matters, you'll recall that during the first year of the Clark administration, every effort was made at economizing and retrenching and of doing away with the deadwood. And then, then they agreed that they would go before the community to get sufficient funds to have what would be considered an adequate program...an adequate program not only in health, but in city government generally.

And it was the philosophy always of the Clark administration, as I understood it, that they felt that the citizens of the community were willing to pay for the services which they required, competently administered. And that was the philosophy.

So, Clark...translating this now to the Health Department,...asked the Health Department, in, I guess its 1954 budget or whatever it was at that time, what funds it really needed to develop an adequate health program for the city of Philadelphia, now that it had gotten its organization going. And we had at that time, somewhere between two hundred and two hundred and fifty nurses working in all of these organizations, of which about a hundred...between a hundred and fifty...well now, I guess they had more than that. They had I guess that number, about, in the Health Department. They had in the Health Department, servicing...they had between two hundred and two hundred and fifty individuals.

We calculated that, for the community to have adequate nursing service according to accepted standards of one nurse per two thousand population or whatever it was, that they would need to have something in excess of five hundred nurses in the city of Philadelphia...in the Department of Public Health.

So, we put five hundred nurses in the budget. We received the money for five hundred nurses, and we were told to go ahead and recruit them. And this was not only in nursing, but it was similarly done in the district health programs. We were going to have ten district health centers; we'd need ten public health physicians and so forth. So we put in an appropriate number of public health physicians to recruit them.

And we found it was absolutely impossible to recruit that number of nurses or really any material increase in the number of nurses. We did, I think, increase our staff by perhaps as many as seventy-five to a hundred nurses, so that we got up in the neighborhood of three hundred, or something over three hundred.
But this was one of the things which in the Health Department and in the city administration generally proved rather visionary and not capable of meeting the expectation, or the standards. And I think that's probably true, generally, nationally. I doubt that there are many places which actually met the so-called American Public Health Association standard for generalized public health nursing in a community.

Now, another area which I think is most interesting has to do with health planning and the evolution of health planning.

(WMP: Before you go into a new thing, would you like a cup of tea?)

Well, I don't particularly want anything, but go ahead if you want to.

I mentioned the fact that at the start of the Clark administration, the City Planning Commission had a health committee and I think perhaps it had other committees. This committee had some staff and the individual that staffed it was a fellow by the name of Auger. And the Health Department, and I believe this was true also of the managing director and the mayor, felt that the departments should be competent to do their own planning. So that one of the first things that was done was to do away with the health committee of the City Planning Commission, and to do away with Auger and his job. And this work, in general, was thrown onto the first deputy health commissioner, who was called the deputy health commissioner for planning.

Now, when this was done, there was no staff in the Health Department for planning. And this was set up on a somewhat of a hit and miss basis. It was delayed in starting, first of all, through the fact that Dixon was not there, to speak of, for the first two years, and as deputy health commissioner, I had to serve as acting health commissioner, and therefore had little time to devote to planning, which requires a great deal of effort.

But subsequent to that we used as staff the secretary of the Board of Health. And interestingly enough, the secretary of the Board of Health was the concept which Dixon actually developed as secretary of the Board of Health, was that we would get a well qualified individual, just out of public health school, to use this as a stepping stone to something else. And in this way he felt that he could get the type of person that he wanted, and that it would be not only a type of training job, but would also constantly get fresh individuals in
the job. And this actually was done for the beginning. The first secretary of the Board of Health was an individual by the name of Dornblaser. He was, I guess, well I don't remember which school of public health he was from, but he was trained largely in medical care administration, and subsequently left the department to become a hospital administrator. While he was there, he really was largely responsible for the development of the health code, with the assistance of the law department, and Helen Chait, who was assigned by the law department as...it was really Dornblaser and Helen Chait that developed the health code.

The next individual following that was named Wolkowiak. And Wolkowiak was the individual who was in office when I really started to do health planning. And it was Wolkowiak along with a public administrator by the name of Mildred Stansky that developed the initial program which went to the Board of Health, went to the managing director, and eventually City Council, in terms of the first program developed.

(WMP: Was that what you presented to City Council? Was that approved in full?)

Well, there was an additional step which Dixon decided was necessary, and to some extent it's interesting, having done away with the health committee of the City Planning Commission...he decided that in order to get the type of document that he wanted, that it would be necessary to require some outside consultation and something to try and sell it to the community. So that he set up his own committee, which was chaired by Morris Duane, and there were two Duane committees, one appointed by Clark, and one appointed by Dilworth, known as...respectively as the First Duane Committee and the Second Duane Committee. And the staff of the Duane committee was the secretary of the Board of Health under me...in other words, I was really planning, but the secretary of the Board of Health devoted almost full-time to this type of thing, and in addition to that, they got an outside consultant from one of the public health schools, an individual by the name of Eller, who proved to be quite competent. And particularly Wolkowiak went around to a number of other large communities, studying the organization of health programs. And the mission that was assigned by the mayor, to the Duane committee, was to determine how health services should be provided to the needy, or the role of Health Department in providing health services to the needy.

(WMP: Did you know that Duane was Joe Clark's roommate at Harvard?)

Well, no, I don't think I actually knew that. But I knew that
he stood in... not to be, that he was well thought of by the administration. I didn't actually know that he was his roommate.

I don't know if I'm going on too long or not, but... I mean I'm willing to....

The Duane report, so-called, or the report of the mayor's advisory committee on medical care for the needy, was a very significant document for the administration, in that it is one of the few reports that I have been... that I have knowledge of, which actually was carried out, almost in its entirety... considering the fact that it did make for some new, strong departures.

Considering the confusion which still centers on medical care nationally, it seemed, so far as I'm concerned, in the city of Philadelphia in 1955 and '6, at the time of the first Duane report, that we knew very much more clearly then what we wanted and where we were going than is the case at the present time.

I presume that is partially the result of the simplicity of our own thinking, and partially the result of the fact that many other factors dealing with economics of medical care have entered the picture since then.

It was decided by the Duane committee, adopted by the Board of Health, and adopted by the managing director in the Clark administration, that local funds... that is, local tax dollars should be used primarily or exclusively for acute care, emergency care, and maternity care. At that time, you may recall, so far as emergency care was concerned, not only was the Health Department involved, but the Police Department was then, and is still, to a limited extent, involved in transmitting patients of all types to emergency rooms of hospitals.

At that time, our studies, that is the studies of the committee, which I served as staff, determined there were in excess of one hundred thousand police emergency transmittals per year to emergency rooms of hospitals. And this type of interest and this type of support is one of the things which made the Duane committee feel that this was a local tax dollar responsibility, and largely, even then, covered by local tax dollars.

They also adopted the attitude that long-term illness of all types, should be state and federally funded. This would in-
clude mental illness, all types of diseases of the aging, all types of tuberculosis, and diseases requiring long-term care....and that the short term hospital stay should be by the joint responsibility of the local tax dollar and the voluntary agency dollar in the community. And if there is one thing which Duane was particularly expert at, it was in reducing policy concepts of this sort to a few words. So that the report that he made is worthy of study by anyone, and gives in a very short and succinct and understandable way, a set of policies which are so easily understood that they can be put into effect.

As a result of this, we studied this staff of Wolkowiak, Stansky and I, in the institutions themselves, The extent of emergency care service, ambulatory care service, and a little later on, the area served by the principal individual hospitals in the community. Interestingly enough, this type of information was not available for many of these institutions at that time. And as a matter of fact, we showed the institutions information which they did not know, concerning the average cost of an outpatient visit, the average cost of an emergency room visit, the average cost of care of a maternity patient, in their institution. We collected these types of data.

And as a result of this, we found that, for example, that the average emergency room visit, in a hospital at that time, cost, it was a little over $5....like $5.12. Now that is not to say that some emergency room visits cost $50 or $100, but many emergency room visits which consist merely of a walk in and observation and a prescription or something like that, in those days, cost perhaps $2 or $3.

It was also the recommendation of the Duane committee for whatever value, that instead of endeavoring to go through a complex system of accounting, such as hospitals did then, and do now, of listing each item beside each name, that for purposes of reimbursement, since you were reimbursed on an average basis, that you would reimburse on an average basis, so that all that you needed to know was how many emergency visits there were in this institution and that the average cost was such and such, and you would give so much per visit, even though the individual visit might be very much greater or very much less than this.

The Duane committee also adopted certain principals, such as there would be a community average, and that they would not negotiate a separate average for each institution. And that if some institutions cost very much more than other institutions, they would still have to pay the average community reimbursement. So these are, you might say, the practicalities of the situation, basic principles on which the program was developed.
In view of the fact that this was being done in hospitals, the health commissioner, that is Dr. Dixon, adopted the attitude that even though it had been... the program had been developed in the health commissioner's office, by the deputy health commissioner, that it would be better that it be administered by the superintendent and medical director of the Philadelphia General Hospital.

And so it was... program having been developed and approved, was turned over to the then director, Lloyd Mussells. And just as an interesting sidelight, to show... you might say... how the hospitals and perhaps then and perhaps even now, think about some of these things, we found that the average cost of maternity care in those days, per institution, was $125....approximately... I mean I'm just using it as a round figure... I mean whether it was $124 or 6, but it was around $125. And as I indicate, the institutions themselves had not--prior to that time, determined their own cost.

Covered in this was a certain number of pre-natal visits, the delivery and whatever the period of post-natal care of the woman at the hospital, but not any post-natal care of the mother or infant after she was delivered.

We suggested to Mussells, therefore, that he negotiate with the city institutions a maternity care per needy patient, at a cost of $125 per patient. He said.... well, that's too much. And he approached the hospital, endeavored to negotiate a better deal for the city, and interestingly enough, at that time, as I recall, .....this is from memory, and my memory may be a little bit faulty... but the amount which the Blue Cross was paying for maternity care at that time, was something in the neighborhood of $70 or $75. So that even though we knew that it was costing the institution $125 to perform this service, Mussells was able to negotiate a contract with the hospitals for $75 per visit.

(WMP: How'd he manage to do that? They didn't know their own costs, is that it?)

That's what I'm saying. At that particular time, now I mean I'm showing you how .... now, I mean, That's not the case at the present time, I'm sure, but at that particular time, they were not that astute... they were not devoting that much time and effort to costs... because, for the most part, they were not being reimbursed by governmental agencies, such as Medicare and Medicaid... I guess they got some insurance coverage, but most of their... as a number of fact, in most institutions in those days, when they were... for many of their ambulatory clinics, they had fees below the average cost... that is,
the maximum fee in the institution for which we calculated $5.12 per average emergency room visit...what was being charged in many of the hospitals at that time was $3 or $4 a visit in the emergency room.

But...it is true that if there were additional services, such as X-ray and what-not, that they'd charge separately for those, which would be covered by our average cost.

Well, I participated myself in what proved to be a caucus of City Council. This would be, I suppose, 1957 or '8, or maybe later...I mean, I couldn't be held to the exact year, in which we presented to the City Council, the essential detail of the Duane report, and the amount of money which it would take to pay for the individuals that were unable to pay, in the voluntary hospitals, for emergency service and for maternity service. And City Council, at that time, agreed with the program, agreed to give an initial amount of money to get it started, with the expectation that it would be gradually increased to cover the total program. And they decided to start on maternity care, and then a year or two later, to start on emergency care, and then to gradually expand from there.

Interestingly enough...I mean, I believe that the first appropriation was $300,000, which would, you'll see, at $75 per visit for maternity care, would take care of guess, or something in excess of 4,000 maternity cases.

And based on our calculations at that time, it would have been possible for about $600,000, to take care of the total needy maternity cases in the community, and for an additional $1,000,000 or $1,500,000 to take care of the emergency visits. So that the total program at that time, just as a kind of a guide post, or considering the enormous costs of medical care at the present time, could have been embraced by the city of Philadelphia, for, I suppose, $2,000,000 or so.

Third Interview - July 10, 1978

Well, I'll continue in outlining the health planning development in the city administration and in the community at large throughout the period that I was related to it.

I had just discussed the importance of the mayor's advisory committee on medical care to the needy, which had been chaired by Mr. Duane, and had as consultant Dr. Eller, of national prominence.
One of the next important forward steps was the request by the state department of Public Welfare for the city Health Department with its planning unit under the Duane committee, to take over the recommendations for Hill Burton Planning in the community.

The Hill Burton construction act was a federal act which supplied matching funds for health care construction and particularly for hospital construction, when the facilities were available to all citizens in the community. One of the basic requirements was that they had to admit individuals regardless of ability to pay. So that proprietary institutions were not eligible, but all of the voluntary non-profit hospitals were eligible, and of course, the public institutions.

It so happened that the federal government early realized the importance of ambulatory care, preventive care, in medical service, generally, so that the health center construction program was a first priority under Hill Burton funds.

(WMP: When did that Hill Burton bill go through?)

Well, the Hill Burton was actually enacted immediately following World War II in the '40's. But it only began to become extensively used in the early '50's, and its initial primary thrust was really to provide health care facilities in less densely populated areas and rural areas. But as time went on, it was increasingly used for the....providing medical care in all segments of the community. And the health center construction, which dealt with ambulatory care, was eligible for these funds, so that the city, which had undertaken this rather large expansion program of health centers....the construction in these health districts... which would have been a very considerable burden to the community, were eligible for about 90% federal matching funds, so that they only had to pay about 10% of the construction.

One element in the use of these funds, however, as they were regulated by the state and I guess, also by the federal government, since there were never enough funds to meet the total demand, was that you could have only one project going, by one agency, at one time. So that this meant that you had to go through the somewhat burdensome task of getting Hill Burton funds for a health center, go through all the bidding procedure, complete the health center, before the next health center was eligible. So that it usually took not one year, or two years, as anticipated, to construct a health center, but usually three or four years. So that this, in a sense, delayed the development of the program,
but at the same time, greatly relieved the local fund situation.

When Duane himself...as Morris Duane himself became quite interested in the question of community planning, and the hospital construction aspect, in particular, and with the idea of trying to get a united force in the community...in the late 1950's....I don't remember exactly which year....1957...1958...he went before the Board of Directors at Health and Welfare Council, which was...I presume, the other principal planning agency...health planning agency in the community at that time, and which had a staff for this purpose and which developed recommendations based upon the information it collected from some two hundred and fifty voluntary agencies and hospitals, that participated in its program, and which it helped to support.

And it happened that I was chairman of the health committee of the Health and Welfare Council at that particular time, so that I had the opportunity, as a member...ex-officio member, of the Board of Directors, to attend the meeting in which Duane appeared. And it was really a very interesting discussion in which there was a.....the board of directors was almost evenly divided as to whether they should accept the offer of Duane to become the principal planning agency of the community, or whether they should not accept it. And it was only by a vote or two that Duane did get the acquiescence of the Health and Welfare Council to develop this community planning agency.

He envisioned a complete planning agency, for both health care and medical care. That is....one aspect which we have brought under our wing was the hospital construction act, through the selection of the Health Department to advise the state, so far as Philadelphia was concerned. The other aspect of it, however, had to do with the actual provision of medical care services to people. And this also involved, even at that time, public funds coming into the community, in terms of the support for the needy by the Pennsylvania Department of Public Welfare, for ambulatory care in hospitals.

So that needy individuals in Philadelphia were.....that is, the hospitals that cared for these patients were given so much per visit for the care of the patient, but the cost which was paid, was much less than the actual cost of the visit.

I can't remember off hand, the exact amount that the state was paying for a visit at that time...this would be in 1956 or '57, but that it runs in my mind it was about $3 or $4...
a visit...a patient visit... no more than that. And any amount which was collected from the patient had to be charged against this, so that the maximum amount that was paid was $4.

You'll recall that when we started the program in Philadelphia, the cost per emergency visit by our own calculation, was something over $5...I think about $5.19 or $5.25. But this rather rapidly increased as time went on. So that by the time within the next five years, the average cost per visit was well in excess of $10. And the state was still paying this low figure.

Duane then conceived the idea...that is, he had two additional ideas. Since he was himself, primarily interested in the hospital construction part of it, he conceived the idea of having a joint-chaired committee, and he induced Bond, Dick Bond, associated with Wanamaker's, to chair the community aspect, while he chaired the medical...the construction part of it.

The other thing which he conceived was that he would like to have created the same way that the original committee on medical care for the needy was what he considered to be a joint community project between the city and the community...he and his representatives representing the voluntary and non-profit medical care aspect. He wanted to set up a planning group. The important thing to be able to plan is to have current data and information on which to base your judgments. And as I've indicated, even though we had made a start on this in the Health Department by using the health commissioner and the secretary of the Board of Health, and perhaps one other staff individual, we did not really have enough staff to develop good and consistent data on a continuing basis. We were at that time working on more or less a one-shot basis.

So he made a proposition to me and to the city, that they set up some type of non-profit organization, for which he calculated the initial cost would be about $75,000 per annum, and he approached me to place in the budget of the Health Department, half of this amount, or $37,500, and he would get the other half of the money from, I suppose, the business community. And...so that I took this as a part of the budget exercise, to the managing director, and through him, presumably to the mayor.

(WMP: Who was that?)

That would be Wagner....Wagner was the managing director at
the time....And interestingly enough....and I can see there might be reasons for it, the city administration felt that they did not want to become involved in this type of a joint planning effort, and turned down the request. And this greatly concerned Duane, because after all, Duane had been appointed by the mayor....this was really, in a sense, the mayor's committee, although he himself, once he got started, took considerable initiative himself, and I think it was probably he that developed the liaison with Bond....but anyway, Duane was so concerned that he came and asked me at the time, whether I would be, if he supported me, go against the administration to the City Council, of the public hearing, and endeavor to convince the City Council that this should be placed in the budget and if I was willing to do this, that he, in turn, would appear and indicate the.....his willingness to supply the rest of the matching funds for the joint project.

But, rightly or wrongly, I refused to do this....this was at a time....I guess it must have been....this must be getting along to 1959 or so, because I was acting commissioner at the time, and I guess Dixon left in August of 1959. So this is now getting pretty close to 1960 that all of these developments.....It had taken this long for all of these developments to gradually take place. And I didn't feel that I was in a strong position as acting Health Commissioner to oppose the administration in this, since Wagner, had...the managing director, had turned it down.

So that this did not go through. Duane, none the less, maintained his interest. Bond worked actively for one year as co-chairman. And, as a matter of fact, he made a principal effort, along with other individuals in the state, and my recollection is that he was successful in having the cost per patient visit increased from whatever this lower figure was.....$4 or $5 a visit, to $8 a visit, as a result of his community effort and appearances before the state legislature, and whatever.

But having done this for one year, he decided....Bond decided, that this was not something he wanted to continue in, and so he discussed this with Duane, and since the city had not been interested in supporting Duane's effort with the planning funds, they decided, by mutual agreement, to dissolve this joint committee. So they had a meeting and dissolved the joint committee, and that committee, as such, was done away with.

(WMP: What year was that...when it was done away with?)

Well, I think this would be about 1960, along in there.
But, Duane had sufficient interest, but he continued to go after money, and got private money on his own, and set up what became the hospital survey committee, which is still functioning today, and has had a continuing important, though limited, effect on health care planning in the community.

Now in setting up this committee, he requested, first of all, Walkowiak, who was the secretary of the Board of Health, who had been working with me, at that particular time, on the data, to work full-time, and paid from private funds. So that this was done, and Walkowiak, for the first few months or year, was the executive or research individual, head of the research office, and they also requested that the city, since they were not going into a major planning effort, turn over our basic data to them. And this was also done, so that we from the Health Commissioner's office, turned over all of our basic hospital data and to the hospital survey committee and... well, the individual that Duane eventually got, as the head, was Jay Helm. And Jay Helm became the executive director and served as executive director of the hospital survey committee for, I suppose, the next ten years or so.

(WMP: John Williams. Wasn't he the chairman of the hospital survey committee after Duane?)

Well, yes....I'm not certain of all of the succession, but Duane remained the key behind this for a number of years still. I'm certain that Duane maintained his leadership in the hospital survey committee until at least 1967, '68, '69.... along there, and even when he left, and others took over this role, he continued for a time, at least, to play a rather key role behind the scenes and in an advisory capacity.

Now the hospital survey committee then took over the Hill Burton Planning Advisory function...the state gave it that function. And in the evolution of health care planning, which evolved in the city, the hospital survey committee has continued to play some role. I might say, one of the reasons that Duane was very much interested in having a public agency, rather than a private agency as the leader in this organization, was because he felt that in order to have community planning which meant anything, that you had to have some type of a teeth or sanction to cause the individuals to participate. And he felt, with some justification, as can be shown from subsequent developments, that the city could be a rather powerful force in requiring medical care institutions to conform to certain practices, particularly as pertains to medical care of the needy.
For example, I already indicated how important the police were, in their emergency vehicles, in taking accidents and other emergencies into hospitals. And when the city began to pay for emergency visits in hospitals, as was recommended by the Duane committee in the late '50's and put into effect in the late '50's and early '60's, the initial appropriations were sufficient to pay for a major portion of the cost. That is, it was the intent of the city and endorsed by City Council, that they would pay the actual cost of a visit. That is, anything which was not collected from the patient. But as time went on and the expenses increased, the City Council failed to increase the amount of money proportionately, so that the city developed a rather interesting device of dividing the money among the participating institutions in an equitable or fair way. That is, they took the total amount of money, they divided it by the number of visits per institution, so they got the percentage of the community load which this institution cared for. And then, at the beginning of the year, they gave them their percentage of the total, and they billed against this allocation until it was used up. And initially, it would be used up, maybe by the tenth or eleventh month, and then it got to be used up by the fourth or fifth month, and so forth, because of the failure to increase it. And at one stage, the...several of the hospitals indicated that unless they received the full payment as they thought they were entitled to, that they would refuse to take police emergency cases. And this made quite a community issue. I think this was about 1965 or '6 or '7....along in there.

And this was discussed before the Board of Health and the community in general, and the Board of Health passed a resolution forbidding them to refuse to accept emergency visits. And the hospitals finally backed down. As a matter of fact, as an interesting aside, present Mayor Rizzo was then commissioner of police and he, supporting the city administration and the Health Department, was a very forceful, as might be imagined, community negotiator in telling the hospitals that they wouldn't dare not to accept any patient brought by a police vehicle.

Now the federal government began to realize more and more, after it had started its Medicare and Medicaid programs in the early 1960's, that it really could not develop satisfactory programs for communities without community input. Prior to that time, most of the programs had been planned centrally in Washington. And the participation in the program was usually on the basis of some initiative of the local community and on the basis of incentives and matching funds. But the policy for the program had been determined in Washington, both as to the amount of money and the type of program. And it became increasingly apparent that they needed more community input.
So that the federal government developed a program known as Regional Comprehensive Health Planning. This was in the mid 1960's....1965....1966. And at that particular time, the state secretary of health, who at that time was Thomas Georges, who was from Philadelphia, called me to Harrisburg, as health commissioner, along with two or three other community leaders from the voluntary agencies....one was Dan Gay from the Hospital Council, and someone from the Health and Welfare Council.....there were, I think, four of us, and asked me as health commissioner to take the initiative to set up the....in quotes..."experimental...regional, comprehensive health planning program for Philadelphia!" And I imagine that he did the same thing for Pittsburgh and other parts of the state. I'm not too aware of what was done in the state, generally, but I am familiar with the Philadelphia situation.

So that we came back to Philadelphia and approached all of the major health agencies, and in particular, their board of directors, asking them to participate to develop regional comprehensive health planning. This required a certain amount of matching funds. In other words, the federal government always required that there be sufficient interest shown on the part of the community, to at least put up some money. But I think the matching funds were very small that were required....in the neighborhood of $2,000 or so. So that we requested each of the agencies to supply a portion of this $2,000, so there were some fifteen agencies, including the city government, each supplying $100 or $200 for this initial planning effort.

Now another thing that began to evolve at this time was the requirement on the part of the federal government that there be true community representation. In other words, most of us, up until that time, had felt if you had a board of directors which was citizens, in contradistinction to health professionals, that that was sufficient community representation. But the federal government made it very clear that it had to be citizens from the grass root communities, citizens from poverty areas, and what-not that were involved. And this was the first time that we had been confronted with a requirement that the board, when it was set up for the agency, would be at least 50% of what we call it...the poverty, disadvantaged individuals on the board. And so this created something of a problem for the agencies. The agency best able to cope with this at that time, was the Health and Welfare Council, in view of the fact that it had a number of regions throughout the city, and had endeavored to de-centralize a good bit of its planning within these regions, and therefore was, perhaps, in a little closer contact with citizens, as such, from the community being served, than were the other agencies.
And it was the regions of the Health and Welfare Council, involving not only Philadelphia but some of the surrounding communities....I think the Health and Welfare Council was working in three counties. And by regional, we mean not only Philadelphia, but the surrounding counties, and even the state of New Jersey. The Health and Welfare Council stimulated the effort to, in some type of a democratic fashion, to have individuals recommended from its health districts. After a year of preliminary planning, this organization was finally incorporated, and did have a board of directors, a large board of directors of some forty or fifty individuals, about half of whom were from the disadvantaged, poverty areas in the city.

(WMP: What was the agency called?)

Well, it was called Regional Comprehensive Health Planning Incorporated. It was an incorporated agency. It had its headquarters in the Health and Welfare Council, and the Hospital Survey Committee continued being the principal unit which had at least some data on community planning. It continued to be the principal source of basic data for this.

Now once the Regional Comprehensive Health Planning Agencies were set up, the federal government then channeled for recommendation....they didn't give the approval, was always left with higher agencies ....the state agency....and the state also recommended, and the federal government gave final approval....but the regional Comprehensive Health Planning Agencies made recommendations for all health grants which came to the Philadelphia region for any purpose. It didn't make any difference whether the grant was for a voluntary hospital...for the Health Department, for any other agency; it went before this group. So this group did exercise considerable power.

Another thing which the federal government was in the process of doing at that time, was to convert its specialized programs to block grants, so that the state or the locality, could select the use was to be put of the money, rather than to have this done centrally. For example....at that particular time, they had money specifically for tuberculosis control, money specifically for venereal disease control, money specifically for maternity care or for immunization programs, and whatnot; so called, catagorical programs. And there was the feeling that a community did not have a true say in the use of its health funds unless it could decide how much money it wanted to put into tuberculosis control....how much money it wanted to put into each of these programs. And so they
started and eventually did convert all of their principal categorical programs into block grants, so that a lump sum of money came to the locality, through the state and the local planning unit, of which Regional Comprehensive Health Planning was one, had considerable power in the control of federal funds and through them, the matching funds.

(WMP: Did this include hospitals?)

Yes.

(WMP: The Hospital Authority then, came later, did it?)

By the Hospital Authority, what do you mean? You mean...

(WMP: Construction money for hospitals.)

No, well you see, the Hill Burton funds....all of these programs which had been functioning earlier, were subsequently involved in this planning process. So that the process was quite a complex one. I mean the state developed a planning agency, and the local recommended to the state, and the state in turn, recommended to the federal government, and the federal government made the final decisions. But the Comprehensive Health Planning Agencies, regionally, had a very considerable influence on what was done...and, as a matter of fact, did, at times, turn down grants completely and wouldn't even process them.

(WMP: Well, some of the grants were for construction of buildings, I suppose, and then some for programs, services.)

Yeah. No involved all....I mean this gradually evolved. The first thing that it took over were the service programs, and then gradually took over the remaining type of programs. I mean the first programs it took over were like...tuberculosis control, immunization programs, venereal disease control, and things of that sort. And then it gradually expanded to include all types of programs.

For example, subsequently, even in 1973 or '4, when I was working in the Federal Family Planning Program, the grant for that agency, I had to take before the Regional Comprehensive Health, and this was a voluntary agency, for which we had a grant request of some $800,000 for the year, of federal funds. This had to go before this group, and be approved by that group, that's just an example of. The process for receiving any type of federal funds.
In addition to that, of course, during this period, the federal government did a lot to increase the power of its own regional offices. Back in the 1950's, most of the decisions...policy decisions in the federal government, so far as health was concerned, were made in the central offices of the Department of Health, Education and Welfare.

(WMP: In Washington.)

Yes, in Washington. They had regional offices, but the regional offices were largely to carry out the mechanics of transmittal, and the auditing, and the reporting back and forth and so forth. And as a matter of fact, when you made applications for grants, you usually circumvented the regional office, or if the regional office was called in, it was called in by the federal government and not by you, because you realized that the decision was going to be made in Washington.

Starting in the late 1960's and the early 1970's, the federal government began to de-centralize a good bit of the policy decisions dealing with the region. And they increased the number of the regional offices, and Philadelphia, which had been one of a number of states, all up through New England and down through Virginia...through the New York office, they now had a regional office for about five states, I guess it is, in Philadelphia, and the regional office of the Department of Health, Education and Welfare, which deals with these grant programs and deals with Regional Comprehensive Health Planning and so forth, is in Philadelphia itself.

While we're talking....before we leave planning, I would like to mention a couple of other types of programs. Another very significant program which the federal government developed in tandem with Regional Comprehensive Health Planning, was what was known as the Regional Medical Program. This was a service and research program for the leading causes of death. And in the Philadelphia area, it became known as the Greater Delaware Valley Regional Planning Program. And it actually involved all the eastern part of Pennsylvania, up as far as Scranton and Wilkes Barre, and all of the southern part of New Jersey. And the principal purpose of this program was to devise methods to combat heart disease, cancer and stroke. A good bit of the involvement was with the teaching institutions and the medical schools, and the service aspects of the program didn't develop as well as they should have developed. And as a result of this, the federal government, just within the last year or two, has phased out this program, although the Regional Comprehensive Health Planning, in a somewhat different form, still continues to function.
Another program which the federal government developed in 1970 and '71, was known as the Experimental Health Services Delivery System. And the purpose was to find out...the federal government wanted to find out what was the best way of delivering health services to a community. And they selected some sixteen or seventeen locations throughout the United States, of different types; large cities, rural areas, medium size cities, groups of counties, and so forth, so that they would have a type of representation of different types of organization. And Philadelphia was, on account of, I would say, largely the type of planning which had progressed, starting with the Duane committee, going through with the Hospital Survey Committee, going through with the Regional Comprehensive Health Planning, and the Greater Delaware Regional Program, had developed a sufficient reputation so that it was the sole large city in the United States, that was selected for the experimental health services delivery system.

(WMP: What was your role in that, at that point.)

They invited applications. I mean, the federal government indicated they had money. They invited applications for this. We, at this time, started to go back into planning within the Health Department ourselves. And we employed, that is I, ...I mean, I don't employ, but I mean, I recommended and there was employed in the Health Department, Dr. Joanne Finley, who had been the health commissioner of Cleveland, during the reform administration that they had in Cleveland, by ...when Stokes was elected in Cleveland, she was the health commissioner there. She decided to leave Cleveland, I think partially because her husband had to leave Cleveland; he dealt with labor law and what-not, and she came East with him and became available. We employed her, and she served as the nucleus of a health planning unit in the Health Department. So that what Duane had envisioned, or at least, what we had wanted to develop back in the 1960's, but we'd never been able to develop, was, for the first time, developed here, largely, again, as a result of federal funds. She was responsible, under our supervision, to develop grant application, and the grant application was, I mean, the Health Unit, that is, governmental health unit, from all over the country, applied for these funds, and we happened to be the large city which was selected for this purpose.

Another thing which the federal government developed, as a part of its effort to see how health services should be delivered, were what were known as HMO's, or Health Maintenance Organizations. The Health Maintenance Organization...the idea of the Health Maintenance Organization is a group insurance. The organization functioning...that is, the individual paying an organization really, to keep them
well, is the idea. Or, to take care of any illnesses that they have, for the fee which is paid per year. When these organizations were first developed by some of the labor union groups, clinics, and one of the ones that was used for example, by the federal government and civil agencies, was the Permenenti Clinic in California, which had been developed by a labor group in California.

And they found that by pre-paying, in the neighborhood of $60, and then it became $80, and then it became $180 a year per person, and I'm not certain what the costs are at the present time....someone like Polk could tell you that better than I could, ....They provide complete health and medical care service for the individual. And there have been two or three attempts to develop health maintenance organizations in the Philadelphia area, with only a small degree of success.

Well, I think I'll go on to another subject. I've talked enough about that.

I'll rapidly go through several other programs which I think the city of Philadelphia did rather forward work, in the mid-twentieth century.

Philadelphia was the first large city to fluoridate its water supply. And this was largely possible through the engineering expertise of Samuel Baxter, the head of the water department.

(WMP: You must have put him up to it, didn't you?)

Well, yes. This was recognized medically, throughout the country, and as a matter of fact, organized medicine was behind it, the Philadelphia County Medical Society strongly supported it. And the Board of Health introduced legislation into City Council and the Health Department set the standards for the fluoridation of the water supply.

In order to fluoridate the water supply, you have to introduce fluoride to come out of the tap at a certain level. This is the tricky thing from the engineering standpoint. So it takes considerable skill from the standpoint of the engineering of the water department, to be able to put the fluoride in the water, to be delivered evenly throughout the system. And one of the things which has slowed it down and prevented it from being done in some parts...areas...has been the great difficulty from the engineering standpoint of delivering the fluoride in proper concentrations. If you get too great a concentration of fluoride, it is really not harmful, but does mottle the teeth....in other words, it makes the teeth not so nice in appearance.
But, then if you have too little, you don't get the effect. So the thing which the Health Department had to do from the standpoint of its standards, that the water delivered from the tap, between such and such concentration per million of fluoride...and gave an upper level and a lower level, and as a matter of fact, the Health Department's duty was to monitor the Water Department, to make certain that the fluoride was delivered, and particularly early in the program, (although they still do it, it's still monitored) but it was particularly important early in the program, because they were less experienced than they are now....

they actually went around through the community and collected water from the various spigots throughout the city and analysed them in the laboratory...this was done in the Health Department laboratory.

(WMP: Is there any way that you're able to measure the benefit to the teeth?)

Well, yes. Well, in addition to this, as a part of this program, the Health Department revamped their whole dental health program. And they recruited... (and this was a part of the work which, I think was done during the Dilworth administration...it was done about 1955 or 1956, I guess)...

Philadelphia was fortunate in recruiting the... a Wisan....I think his name was Jacob Wisan, although I'm not absolutely certain of his first name, who was one of the outstanding, if not the outstanding, public health dentists in the United States at the time. And the program which he developed in Philadelphia was a model program nationally, during all of its formative years.

Prior to the use of fluoride, almost the only thing which a dental health program did in the clinics, was to look at children's teeth, occasionally do some fillings, but for the most part, extract teeth which were decayed. And Wisan did away with that type of a program entirely, and developed what became known as the incremental dental health program. And Wisan did not, you know, abandon teeth in older individuals. But he decided that the effect of fluoride in preventing dental decay would be so significant and important that there was no particular reason to worry about older individuals who were... who already had the decay. And therefore he started the first year with the care of the first year children...the second year with the care of the second year children...and so forth. And so each year he extended it a year, until he got, you know, through the twelfth grade, through high school.
At that particular time, for instance, this program was started in 1954, and by the time of 1960, which would be six years later, and six years of use of fluoride, the estimated saving per annum, in dental care, was about $2,000,000. And each year they calculated 75,000 teeth saved, and so forth and so on...which they were able to calculate and prove on practically a mathematical basis.

It was very unfortunate that Wisan, after having started this program, I think, in the third or fourth year, 1958 or 1959, developed a brain tumor and died. And fortunately he had developed a young individual by the name of Soricelli, who was familiar with the program and Soricelli stuck with the program and carried it on, and is still in the Health Department, as a matter of fact, he's been promoted in the Health Department and is head of the...acting head of the Community Health Services at the present time.

So that was one outstanding program. Now I'd like to talk about air pollution control, which was one of the really outstanding programs, and having heard of Duane so much in the medical care program it's interesting to note that he was the first chairman of the Air Pollution Control Board, and really, before he got started in this other program, really got the air pollution control program underway.

The charter required that, as a part of the health code, there would be an air pollution control code developed. And our charter is really very sophisticated in its approach to air pollution control, and made, just from the charter requirement, made Philadelphia in the forefront in the nation from this regard, through this requirement.

For example, it recognized in the air pollution control, the need of having knowledge of, not only the community aspect of air pollution control, but actually the engineering and industrial and manufacturing aspects of air pollution control, and required that the Air Pollution Control Board have qualified individuals, as specifically stated in the charter.

At that particular time, there were a few areas of the United States where they did have air pollution control programs, and Philadelphia was one; even before the charter, Philadelphia had a division of air pollution control, and what was recognized at that time as a rather expert individual in air pollution control.
The idea of air pollution control, however, in those days, was principally directed toward particulate matter in the atmosphere. In other words, the principal thing which they did was to detect smoke rising from chimneys, and they had a so-called Ringleman chart, in which they could compare the density of the smoke on this chart, and the principal air pollution control law would indicate that in a combustion process, a factory could not discharge pollutant for more than three minutes, three times a day, with a density of over such an amount on the Ringleman chart. I mean, that is principally what air pollution control consisted of, and as a matter of fact, in some parts of the world, particularly in Great Britain, they called it what it really was, smoke control.

And most of the individuals who were air pollution control experts, and I'm not indicating that they were not expert for what they were doing, were combustion engineers, of some type or another, who did the best they could to try to control smoke emission through a series of inspectors, to fining individuals when they created too much smoke. Factories controlled the situation by building higher and higher chimneys, and thus disseminating the stuff that came out further and further away...what it principally did. And then they also developed a means of washing the stuff as it went through the chimney, to take out the particles and whatnot. But that is what the program consisted of.

Well, the air pollution control code, which was developed quite largely by Duane and, more important than that, negotiated with the community, by the way, in other words, it was really Duane who held the initial public hearings with the industries of the community, and had them to accept a code which would, in effect, control gaseous emissions of all types; even...one of the somewhat unique features of the program when it started was that it controlled odors, although there are problems in getting standards of what an odor is, because a nose is not as good a device for detection as some other things.

(WMP: Something made me think that maybe Duane was on the air pollution control before the Clark administration, is that right?)

No, he was not. No, he was appointed...and, as a matter of fact, the head of the Air Pollution Control Unit, did not have sufficient chemical and other types of engineering experience to really supervise the development of the type of program which was necessary for the new code. And the individual whose name was John Hodges, after some preliminary discussion with the board, and some rather frank discussion within the staff and particularly with Deputy Commissioner Stubben, who was in charge of environmental health,
the deputy in charge of environmental health, came to the conclusion that...he was not what was wanted, and on rather short notice John Hodges resigned and sought employment elsewhere. 

---interuption.....tape change------

...Well to continue, John Hodges, to indicate the respect that we was held in, nationally, went immediately and took over the air pollution control program in Cleveland and continued as the air pollution control director in Cleveland until he died several years later. (He died suddenly)

Now, of course, even in the area of particulate matter, there was still a great deal to be done at the time of the Clark administration and the new air pollution control code. And the two important things which they did early, which had not been done previously, were to do away with the open burning dumps, and open burning in general. In other words, open burning of any sort was prohibited.

There were all types of open burning going on in those days, I mean, everybody at home burned their leaves, and a good many individuals felt the nice smell of burning leaves in fall was....and as a matter of fact, it was not easy to convince the community that they had not to burn their leaves, and not burning things, of course, means that it has to be disposed of. And many of the scavengers and other individuals burned, in addition to open burning dumps,....lots of individuals burned in the open. I mean if you had a construction site and took down a lot of trees, you burned up the trees, or they burned up the railroad ties, or they burned up anything that they wanted to get rid of, in terms of waste.

So that during 1955 and 1956, so that by the end of 1955, open burning, as such, was done away with in Philadelphia. This of course, necessitated, to some extent, hauling wastes out of the city for so-called sanitary land fill, or erecting incinerators. And the incinerator program was developed according to Health Department standards, but of course, developed by the Department of Streets in accordance with our standards to keep, again, polluting the atmosphere from the burning.

Another thing which individuals of this generation, at least, find they're not familiar with are the smoke burning locomotives. And in those days, all of the large freight trains, of which there were many, passing through Philadelphia, used smoke burning locomotives. This, however, proved to be easier to get rid of than perhaps anticipated, because the eastern corridor had been largely electrified, and although it wasn't practical to do all their freights with electric locomotives, they could use diesels. So that there was practically...
All that was really necessary was to indicate that no longer locomotives would be smoking coal-burning locomotives would be permitted in the city, and the railroads conformed rather readily.

Now, the approach to air pollution control had to be done on an industry basis. And Duane and the air pollution control board were particularly successful in initiating these programs. The reason it has to be done on an industry basis is because to control air pollution is an expense; if you're going to do away with the emission of gases into the atmosphere, or if you're going to deal with the absorption of fumes, you have to change your processes and it costs the industry, and eventually, of course, it goes right back to the public. And it's not practical to go against one factory or industry. So that the only way that you can get cooperation is to develop a program for the oil refineries or to develop a program for the smelting, the metal smelting industry, or for whatever other group of industries you can envision.

And the industry individuals are drawn together...they assist as a matter of fact, in developing the standards, in terms of knowing what the state of the art is, and as long as all of the individuals are willing to conform, it proved to be possible to get larger violators. I mean it takes two, three and four years of working with a group of industries before their control mechanisms meet standards.

Now, I would say that the initiative again, which had the greatest influence, however, in all localities, was the Federal Air Pollution Control Acts and programs, which were developed in the early 1960's, in which, again, using the carrot and stick approach, the federal government agreed to finance major portions of local air pollution control programs provided they maintain a certain level of standards. And it was largely the federal government which really began to set the standards for the sulphur dioxide, oxides of nitrogen, and other types of chemical substances which come into the air, and it was up to the localities, to develop a program which would reduce the level of these substances in the ambient air.

In order to do this, you needed air monitoring systems, which were unknown when the original air pollution control code went into effect. And the principal thing that they did in those times, was to take a sample of air and then take it into a central laboratory and analyze it, or take stack emission and analyze the stack emission, and so forth and so on.
for all large localities to develop very sophisticated chemical analysis systems. And the analysis systems became so perfected that they could really be computerized and within the next...oh, say...ten years...eight or ten years...up to about 1970 or so....and this still being perfected, the air pollution control unit developed branch laboratories throughout the city...that is, monitoring points. And the air monitoring could be analyzed mechanically, and now sent in to a central computer, so that you know what the level of carbon monoxide, nitrous oxygen, sulphur dioxide, and also particulate matter, is at any time throughout the community, and where it goes up and where it goes down, and as a matter of fact, you can even trace sources by finding that this particular pollutant appeared in northeast Philadelphia, or southwest Philadelphia or what-not, and sometimes trace it to its source in that way.

Philadelphia and other communities also, as a result of this, developed so-called air pollution control index, which became published in the paper, as part of the weather, and also were able to have alert systems, indicating when the public might be in danger...never has there been....There has never been, really, a serious air pollution control alert in Philadelphia, but of course, in some parts of the world, there have been serious air pollution problems. They've occurred in London, they've occurred in the Monongahela Valley, they've occurred to some extent in Los Angeles, where they have so-called inversions on account of the mountain air....where deaths, not usually of healthy individuals, but individuals who have a reduced lung capacity, on account of emphysema or severe cardiac disease and so forth, can be killed as a result of the air pollution situation.

I don't know how much interest this is, but is there interest from those that are interested in public administration. It was the feeling of, I think, the charter, and of also Dixon and myself as health commissioner, that the air pollution control was a part of environmental health. And as such, the director of air pollution control program would come under the head of the Environmental Health Division, and in a sense the Air Pollution Control Board had a subervient position to the Board of Health and what-not. This proved to be an administrative problem from two standpoints. First, the Air Pollution Control Board and...that tended to be too far removed from the community and community planning, and in addition to that, placing the head of the air pollution control unit, under the environmental health individual, made a salary problem, when in actuality, the individual to run a modern air pollution control program required such knowledge as to command a very high salary. So that, having started out as an air pollution control section of the environmental health unit, the next step at the insistence of the Air Pollution Con-
control board, was that the Environmental Health Unit became known as the Air Pollution Control and Environmental Health Unit. And they felt that by placing air pollution control first, this would indicate the importance of this, but even this was not sufficient. And they finally made a so-called Air Title—did away with the term air pollution control, and called it air management services, as being more indicative of what the unit really did, and they created and Air Management Services with a deputy commissioner of health in charge of the air management services on equal capacity as the environmental health head. So that is just an interesting aspect, from the standpoint of public health administration.

(WMP: May I inject a question. What did you do about the pollution that came across the river from New Jersey, or came up the river from Delaware, and so on?)

Well, of course, you're confronted with...first of all, for the most part, with prevailing winds. And for the most part, it was Philadelphia contaminating New Jersey, because the principal flow of air is from west to east. And very seldom did ........

(WMP: Well it does come up sometimes in the summer....)

Well, it does, occasionally. There's nothing which the health jurisdiction in Philadelphia can do, other than to complain to the adjacent health jurisdiction.

(WMP: I thought you might have had some arrangement with the other states.)

They worked together on a regional basis, and that is where ...the federal government steps in, you see. The fact that they have a National Air Pollution Control Act and all of these units are really receiving federal funds under a joint program makes it...So that, more than almost any other program, the Air Pollution Control Program or the Air Management Program, is a regional program.

(WMP: Interstate, actually.)

And interstate, yes.

Well, perhaps we should mention some....I can go on to many other things. You brought up the question of tuberculosis control. And tuberculosis is one of the diseases which has largely been controlled in the mid-twentieth century. At the time the charter came into effect, there were more tuberculosis patients that needed care than there were hospital beds, in spite of the fact that they had whole hospitals
devoted to nothing but tuberculosis patients. For instance, the Philadelphia General Hospital alone, had two hundred fifty to three hundred bed facility just for tuberculosis patients. There were state sanitoria, which had thousands of patients, I mean, three and four thousand patients, like Mount Alto, and what-not, and as a matter of fact, early in the Clark administration, the state health department converted and reconstructed the old Lankenau Hospital into the Landis State Hospital for Tuberculosis Patients, which had a capacity of about three or four hundred. And in spite of all that bed capacity, and in spite of the fact that there were tuberculosis clinics with many, many patient visits, there was a waiting list of four or five hundred patients with no adequate facilities to go to, so that they were at home, infectious, transmitting the disease to others in their own household.

Now, the thing above everything else however, which made it possible to control tuberculosis, was the development of anti-tuberculous drugs which were effective against the tuberculosis bacillus. And these were streptomycin, and we had penicillin for gonorrhea and syphilis, and streptomycin was very effective against the tuberculosis bacillus, and another drug known as isoniazid. So that individuals .... Streptomycin was a little....that is, it has certain side reactions if given over a period of time....it may effect the auditory nerve and what-not, it has to be watched, so that streptomycin is not too good for prophylaxis, but isoniazid is. So that the Health Department, of course, as soon as these drugs became available, made them available to its patients, and by 1955 or 1956, the waiting list for tuberculosis patients was done away with completely. And at the present time, really, the tuberculosis institutions as such, have been done away with, if they're in existence at all, have been turned over to the care of other chronic illnesses, or childhood diseases, or something else. So that this is one of the medical miracles which has occurred in the recent past, but really is largely the result of the application of effective drugs for the treatment of tuberculosis which they never had before.

Another similar program in which Philadelphia was in the forefront had to do with polio. In the 1940's and the early 1950's, polio outbreaks in large cities during the summer months occurred with great regularity, and there was hardly a year in which Philadelphia didn't have thirty or forty or fifty cases, and sometimes many more than that. And many of them advanced to quite serious stages of paralysis and those that survived often had permanent paralysis. In places like the northern division of the Philadelphia General Hospital, which was the old contagious disease hospital that took care of patients on a regional basis and had individuals in respirators, ten, fifteen and twenty patients constantly in respirators that would
die, if taken out of the respirator. Well, of course, this again was overcome with the development of the Salk vaccine. And the principal immunization program in Philadelphia was done by ....I can't really remember the year, but it was done in the '56, '57, '58....along in that period, in which the Junior Chamber of Commerce, plus the Philadelphia County Medical Society, plus the Health Department, plus the public schools, developed an immunization program to immunize all of the children of Philadelphia in clinics in a series of three or four weekends during the summer months. And this wiped out polio. I mean the next year, there were no cases of polio for the first time.

(WMP: Just in Philadelphia, of course.)

Well, I mean, I'm talking about Philadelphia, but I mean this was done nationally, but I'm telling you how it was done in Philadelphia.

So that, polio, of course, can still become a serious disease and there have been, within the last year, outbreaks of polio, in several parts of the world, but not in the United States in recent years.

Another program which we mentioned, and I don't know that there's too much more to say about it, other than that Philadelphia, having developed a mental health program, recognized the importance early in the Clark administration and starting with the program in 1954, was able to take advantage of the federal mental health and mental retardation act, which went into effect in 1966. And we began to get a vast amount of we began to get good amounts of federal funds through the state of Pennsylvania, and matched by funds from the state of Pennsylvania in 1967 - '68. The city was divided into twelve districts. Facilities for the care of ambulatory mental cases were developed in each of these districts. The philosophy of hospitalization, on a national basis, was changed, with the idea that there are very few mental patients which cannot be brought to the state of being able to go back into the community under supervision. So that mental hospitals which used to be overcrowded and had, even then, four and five thousand patients have virtually ceased to exist. I mean the mental hospitals have a few patients which are kept often for periods of three to six months, to be placed on adequate treatment and then returned to the community for supervision.

(WMP: You put Byberry out of business, did you?)

Well, Byberry is virtually... I don't say... There is a Philadelphia State Hospital, which has a few patients, but in the...
parison to what it was, there is not a need for a large hospital facility.

One that you mentioned before, Frazier, Charlie Frazier, in terms of Philadelphia General Hospital, I would say the greatest contribution as a life-work that Charlie Frazier did, was in the development of the Pennsylvania Mental Health and Mental Retardation Program. He was one of the foremost individuals in the country along with Kenneth Apple, to stand behind the federal legislation and Charlie Frazier, at the time the federal legislation went in effect, and it became necessary for the state of Pennsylvania to draft legislation and to develop a program, was called, in the state of Pennsylvania, by all who knew him, Mr. Mental Health! That is what they called Frazier. And he is largely responsible for the public support which got the Pennsylvania Mental Health and Mental Retardation program through the legislature...in Philadelphia, while he was a part of the Philadelphia General Hospital Board of Directors and chairman. He also, through his personal interest, developed the program in the West Philadelphia area and got the University of Pennsylvania and the Philadelphia General Hospital interested in going into the program, and as a matter of fact, I attended the meetings with Harnwell, who was then the president of Penn....in getting them involved in the program.

So that Philadelphia has, an outstanding mental health and mental retardation program, and a well-known mental health and mental retardation administrator, Leon Soffer, who has been in charge of the program ever since it was set up. He was the initial individual who was selected to develop the program, following Linden. Linden started the program under Clark, but Linden was a physician in private practice and did not want to devote really, full-time to the program.

(WMP: What was the method of treating mental patients. Was it drugs? or therapy?)

Well, they have supportive therapy. They have group psychotherapy...something which has been developed. And in addition to that, I suppose, what has developed more than anything else, are tranquilizers, to take them through their acute episodes, and as a matter of fact, and this is really worldwide, not only in the United States,...there was a great abhorrence on the part of the public, of mental patients, and once an individual went insane, so to speak, he was more or less considered hopeless. And he was institutionalized and placed in an institution where he was out of contact with the world. And after he had been in an institution for a time, there was really no way of getting him out. The law, in these days, are really to protect the patient against the prejudices
of society. And a lot of things which the mental health and mental retardation units do throughout the state is a continuing education process to all members of society to... as to how to get along with these somewhat abnormal individuals.

Another thing which has developed over the years are so-called Horizon Houses, after the original Horizon House which was developed in New York. But these are half-way houses back into the community. You see, an individual who has had a mental break, frequently loses a lot of confidence in himself, and feels that society is prejudiced against him, feels that he cannot go back... so that he needs a lot of help and support..... from his family, from the community, from such organizations as halfway houses and what-not. And what has been developed... the other thing that has been developed is the tranquilizing drugs to take them through acute episodes. And with the use of tranquilizing drugs, plus an understanding on the part of the family, the community, and what-not, as to what needs to be done for this ill person, it is possible to take almost all of them back into the community and they become useful citizens in one capacity or another. I mean they oftentimes... have to live a somewhat sheltered existence and, if they have an acute episode, as a part of the program, they have developed what they know as crisis centers. You see, all of this is a part of the program. It consists of a crisis center, in which a family or an individual himself can call into the crisis center 24 hours a day. And somebody's there 24 hours a day to take care of them. And they can go and see them, support them, make appointments for them, if necessary.... take them to a mental institution. And a mental institution, instead of being a large place where a person is committed for life or for an indefinite period of time, the individual usually goes in on a voluntary basis now, and commits himself for a long enough period of time, to get back on his feet. So this is, in a sense, the way mental illness is treated these days.

(WMP: That's fantastic.)

Another thing in which Philadelphia was among the forefront, was in poison control and in suicide prevention. As an interesting corollary of the medical examiner's office, you'll recall that one of the things which was developed during the Clark administration was the medical examiner's office to take over the old coroner's system. And as a part of the medical examiner's function, they developed a very highly skilled laboratory, one of the principal functions of which was to detect poisons, because one of the ways that a person dies through committing suicide is to take poison or sometimes individuals are poisoned in other ways. So a very important function of a medical examiner, or a coroner
is to determine whether poison or overdose of drugs or anything else was a cause of death. So they developed very sophisticated equipment.

In doing this, Philadelphia developed a poison control center, not only for Philadelphia, but all the surrounding areas. So that, anyone...I mean, you, anyone, or a physician, who is confronted with a possible case of poisoning, can call in to the Poison Control Center and find out what to do. In other words, if an individual has...if a child has eaten shoe polish, or something like that, or just as an example...it doesn't tell on the shoe polish what's in it, or what to do or what-not. Well, the Poison Control Center knows what's in shoe polish. They know what you should do for it. They tell you what to do. And having developed a 24 hour service, from that standpoint, and also through the mental health unit, they also have developed a suicide prevention center, which is manned 24 hours a day...in which an individual, and most individuals that do commit suicide, know that they're going to do it, and oftentimes want it to be known that they are committing suicide. So that it is often...this possible through a suicide prevention center, operating 24 hours a day, to prevent many suicides.

(WMP: Well, other people are trained to sort of diagnose a situation and call in, and get help, and so on?)

Yes, they can. But, I mean, the principal thing, which, as it turns out, a suicide prevention center does, is really to deal with the individual himself who is contemplating suicide. I mean, that is, as it turns out, is one of its principal functions, and you know, there are occasional dramatic cases in which, while the individual is talking on the phone, you can get in touch with somebody else and tell them, and they can go and see the individual in the interim. I mean, all those types of things can occur, but those are the exception rather than the rule. I mean, the usual thing is that the...I mean, many cases of suicide can be prevented, just by the individual having a place to call up and talk to somebody on the other end of the wire.

Well, are there any things that you want to ask of me. I mean I think I've certainly exhausted you.

(WMP: I think you've done a fantastic job! I've learned more from you than anyone else I think I've interviewed. Of course, I didn't know much to start with, in your field. But, it was terrific. Would you like me to send a copy of your interview, parts of your interview, to Morris Duane? You've said so much about him and so on.)
Well, there are other individuals that...Duane, Duane...
I'm not in contact with Duane recently....I'm certain that Duane would certainly have very interesting points of view, and would know many things which I don't know about the way in which he dealt with various individuals in the community. Whether he wants to talk about it or not, that's another matter.

(WMP: I just thought he might like to have it for his own archives, so to speak.)

I think, you know, somebody like Charlie Frazier in Mental Health is there also.

(WMP: He's a great guy.)

I have no doubt that he would be very willing to talk...I also suggested the possibility of getting Purdom. Purdom organized the original environmental health unit. He's an individual of national prominence. He was, as a matter of fact, the only president of the American Public Health Association from Philadelphia in recent years. And he's a professor and on the teaching staff and head of the department at Drexel University. And he would be a good individual. Of course, you're going to talk to Polk, and I certainly think that Polk could give you perspective...I mean, After all, I haven't been in the Health Department for seven years now, I guess. And he knows better the way things are going, and some projections for the future and what-not, that'll be a lot more valid than anything I could say. I've suggested....I think it would be very interesting to talk to someone like Dixon. I don't imagine that you have money for expenses or anything like that, and Dixon's down in North Carolina now, but I have an idea that he may sometimes come to Philadelphia. He might be quite interested in something like that. Those are the types of individuals...if you want additional type of material, I think all of those individuals would have very interesting and somewhat unique things. I mean each of those individuals that we have discussed, made a very unique contribution to the development of what turned out to be a very outstanding program developed during the Clark and Dilworth administrations, and projected, as you can see, has had far-reaching influences up to the present time.