YOUNGSTOWN STATE UNIVERSITY

ORAL HISTORY PROGRAM

History of Medicine in Mahoning County

Medical Training, Practice, Associates and Problems

O.H. 73

FRANK G. KRAVEC, M.D.

Interviewed

by

Paul Zimmerman

on

November 26, 1974

DR. FRANCIS G. KRAVEC

Dr. Francis George Kravec was born on December 15, 1909 in Youngstown, Ohio, the son of John and Johanna Kravec. After his graduation from Fitch High School in Austintown, he decided to become a doctor because he felt that medicine is a field in which it is possible to do more for mankind than in any other field. Also, Dr. Kravec wanted to be his own boss.

From 1929 to 1931 Dr. Kravec went to Miami University in Oxford, Ohio for his pre-med education. He then continued at Loyola University in Chicago, Illinois to obtain his Bachelor of Science in Medicine, Masters of Science, and Doctor of Medicine degrees. He then interned at Cook County Hospital, a charity hospital which was at that time the busiest and largest hospital of its type. Following this, Dr. Kravec went to Cleveland and practiced industrial surgery for about a year. At Cleveland City Hospital and Sunny Acres Sanatorium he took up his post graduate work in chest diseases, coming back in 1946 to a position in Youngstown as resident physician at the Mahoning County Tuberculosis Sanatorium. Six years later Dr. Kravec went into private practice.

Dr. Kravec belongs to the Mahoning Medical Society, Ohio State Medical Association, American Medical Association, and is a Fellow of American College of Chest Physicians. He has also won the

Distinguished Professor Award at Youngstown State University. In his spare time, Dr. Kravec enjoys leatherwork craft, golfing, and woodworking.

ELIZABETH A. REITZEL
August 10, 1978

O. H. 73

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INTERVIEWER: Paul Zimmerman

SUBJECT: Medical training, practice, associates, problems

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Z: This is an interview with Frank G. Kravec, M.D. for the Youngstown State University History of Medicine Project of the Mahoning Valley by Paul Zimmerman at 243 Lincoln Avenue, Youngstown, Ohio, on November 26, 1974 at 4:00 p.m.

Z Dr. Kravec, what influenced you to become a doctor?

K: The chief reason was, that it is a field in which you can do more for mankind than in any other field. I, also, felt that I would be my own boss in this particular field.

Z: At what time did you make this decision?

K: I made that decision soon after I graduated from Fitch High School in Austintown.

Z: Where did you go to do your pre-med?

K: I had a scholarship at Miami University at Oxford, Ohio, and I spent two years at Oxford in pre-med. At that time, in 1929, you only needed two years of pre-med education to get into medical school. From there, I went to Loyola University in Chicago, and I spent five years in medical school there. One year I was a research fellow in pathology and also a teaching fellow in pathology. Following that I interned at the Cook County hospital, which was at that time, the busiest and largest hospital of its type; a charity hospital. It contained 3200 beds and all of these beds were free beds.

The patients were not permitted to pay any of their hospitalization. They had free hospitalization plus free surgical and medical care. Of course, at a big hospital like this, you saw every type of disease imaginable. I spent 18 months as an intern at the county hospital.

Following this I went to Cleveland and I practiced industrial surgery for about a year. After that I took up post graduate work in chest diseases in Cleveland City Hospital and Sunny Acres Sanatorium. In 1946 I came back to Youngstown and was a resident physician at the Mahoning Tuberculosis Sanatorium. Six months later, I started the private practice of medicine at 243 Lincoln Avenue, where I am still practicing. I'm a specialist in chest diseases and internal medicine.

Z: When you were going to medical school, how tough was it?

K: Well, when you go to medical school, you really have to work hard. Of course, most medical students are hard workers and they spend most of their working time studying, or going to school. They have very little time studying, or going to school. They have very little leisure time for extra curricular activities. Of course, at the same time, I worked my way through medical school, so it took a little extra time. I worked two years as a first-aid man, for the Youngstown Sheet and Tube Company at Indiana Harbor. We really acted as first-aid men, equivalent to the nurses that worked the day shift.

Z: What degree did you graduate with?

K: I really have three degrees, and they were all obtained from Loyola University in Chicago; Bachelor of Science in Medicine, a straight Masters of Science, and Doctor of Medicine, the M.D. degree, so I have three degrees.

Z: Could you tell us what a typical day was like when you were an intern?

K: We really worked twenty four hours a day. We were interns and for as long as we were in the hospital we lived on the seventh floor of the hospital. There was always a phone there, so you were on call continuously. It was really a tough internship. We had ninety interns working continuously. At that time, residencies were just beginning so we had very few resident physicians. Most of the work in the hospital was really done by the interns. Of course, you saw every type of disease imaginable. You saw all kinds of injuries, and especially on weekends. You'd have a lot of stabbings,

shootings, and automobile accidents. The interns were really busy starting Friday night. In fact, the first day that I was there, I worked for thirty-six hours straight without a rest. Then I decided, well, that was too much! After that, we slowed down to about twelve hours a day.

Z: Well, that's quite an

K: It was just a little too much. You just can't take care of everybody. You have to take time off for yourself.

Z: You have to have time to regenerate a little bit. Did you get any pay for this?

K: No, at that time in 1938 to 1940, the interns at Cook County Hospital received absolutely no pay. The only thing that we did receive was about $10.00 worth of white uniforms. They furnished us with three pairs of white pants, three coats, and you had to buy your own shoes. Of course, at the present time the same interns at Cook County Hospital are making approximately $9,000 per year.

Z: Are they as busy?

K: They are as busy, but there's not so many seeking this particular internship. When I took the internship, we wrote a special examination. There were about 400 medical students that wished to take this particular internship. So they issued an entrance examination, where you wrote on ten questions per day for three separate days. These papers would be graded by the attending physicians. Those with the highest grades would receive the internship. Because of this, I was chosen as one of the interns for the first part of the course. They usually took two sets of interns. The first one would start July 1st, there'd be about 30 interns. The next group would start January 1st, 6 months later. Then, there was an in between internship called the middle internship, where you spent 6 months in the specialties. So altogether we had about ninety interns working for various divisions of this hospital. This hospital occupies a whole city block in Chicago and it's still present and operating. In fact, one of my roommates stayed on as one of the medical officers and he's still there as the head of the hospital.

Z: Was this kind of competition common among medical students?

K: It was common at that time, because everybody wanted to intern at Cook County Hospital. It had a wonderful

reputation, because you saw all types of diseases, and not only that, you got to do a lot of work. You did a lot of the surgery yourself and you handled the patients and supervised the treatments. Also, there were a lot of clinics associated with the hospital. So you worked at the clinics and the hospital at the same time.

Z: Did this help you make up your mind as to what you wanted to specialize in?

K: Yes, because when you saw the different specialities, then you decided just what particular field you'd like to join. I chose internal medicine and chest diseases.

Z: When you first started your private practice, did you go to industrial medicine first?

K: For a year, then after that I went back into the speciality of chest disease.

Z: When was that started?

K: That was in 1942.

Z: What were conditions like then, in your field?

K At that time, we had a lot of tuberculosis in the country. The death rate, at that time, was about 37 per 100,000 population. Of course, at the present time, it's down to about 1 per 100,000. In fact, just one year ago, we closed our home sanatorium out on Kirk Road, because we ended up with only one hospitalized patient. We finally transferred him to a general hospital. We felt that we had really cured all of the tuberculosis in Mahoning County. So there was no reason to keep this hospital opened. Because of that it's good enough to stick to just one particular field of endeavor. If you're doing internal medicine, you can always fall into another field. Now that we've cured tuberculosis, we have other diseases to treat. Pulmonary emphysema is a rather serious type disease. I'd say that about 35% of the people on social security disability are suffering with some form of respiratory disease. We are treating these particular people, with their respiratory diseases. Most of these are emphysema, which is brought on chiefly by smoking cigarettes and also by pollution that is present in the air of the larger cities.

Z: In connection with this work, have you ever had any firsts in medicine?

K: No, not particularly. I'm sort of a patient's doctor, so I'm not a person who goes out to do research work. I believe in just taking care of the patient, seeing that he is well taken care of, and that he gets well. I want him to be able to get back to work. Usually the research men are present around the university area. They have jobs that do not require too much time as far as patient care is concerned, but then they have extra time to do some research work. Most research work, I feel, should be done in an area of a medical school.

Z: How about in Youngstown, did you have any 'firsts'? Have they learned any new techniques or methods in Youngstown?

K: I watched the first chest surgery done in Youngstown. In fact, when I was still at Cook County Hospital, chest surgery, that is surgery on the lungs was just beginning. At that time they were first doing thoracoplasties, which is a plastic operation on the thoracic cage. Later on, they were opening the thoracic cage, to remove cancerous lungs and this was the earliest type of lung surgery.

In Youngstown Dr. Keogh, who also was a physician in this building; had his office downstairs. He became an attending physician at the Mahoning Tuberculosis Sanatorium. He began to do the lung surgery in Youngstown. He was the first lung surgeon that we had in Youngstown. I would help with the diagnosis and with the surgery in this type of lung surgery. Unfortunately, this very promising young surgeon died unexpectedly at a very early age. Evidently, he had had a heart attack during the night. He passed away in 1948 or 1949. Of course, since that time we've had several other lung surgeons and heart surgeons come to town to take his place.

Z: So you haven't had that much to do with actual surgery yourself?

K: No, I'm not a surgeon. I'm a medical man. I used to help with the surgery.

Z: When you were first opening up your practice, back here in Youngstown, just who came to you and why?

K: I first opened in practice as a specialist in chest diseases and in internal medicine. So almost from the opening of my office I had sufficient patients. Even up to the present time I probably take care of between 40 and 60 patients a day. It takes a pretty full schedule. I have almost a clinic here, because

I have a lot of different instruments. I have an x-ray machine with a fluoroscope, I have a pulmonary function machine, which is used to test patients with lung disease. I have an electrocardiogram, and I have the different types of oxygen machines for treatment of the patients.

Z: What kind of a relationship do you have with the County Tuberculosis Association?

K: Well, that's sort of a private organization. The function is really not a medical function. They are just to educate the patients as to the presence of various types of lung disease. Merely to publicize it, so that these patients can go and seek medical care from their private physicians. Some of these patients, however, do go to clinics. I think your best treatment is to first go to your family physician, let him diagnose your case, and then he can either send you to a clinic, or send you to a specialist that deals in that particular disease.

Z: What made you decide to come back to Youngstown?

K: Well, I was born in Youngstown, for one thing, and that's the reason I came back.

Z: You had a special feeling for it?

K: Yes, and I had my family here. I have a big family.

Z: A typical day in your office in 1946 or 1947, what would it have been like?

K Usually, I would get to the office after I made my hospital rounds. I made hospital rounds at North and South Side Hospitals. Occasionally, I went to St. Elizabeth's Hospital. Then I'd go to the sanatorium, at least once a week after I got through with my residency at the sanatorium. Also I have been the chest disease specialist for Woodside Receiving Hospital since about 1948. I read the chest x-rays, and advised the doctors at the Woodside Hospital concerning the diagnosis and treatment of these various chest diseases. After you make the hospital rounds, you'd come to the office. You'd get there between 9:00 and 9:30. From then on, you see patients all day.

For a chest disease specialist, it's impossible to practice medicine without an x-ray machine. Just like the heart doctor trying to practice without a stethoscope. So with the x-ray machine, the electrocardiogram, and these other machines, you spend at least six hours a day in the office. Of course, after office hours you

usually have to make rounds to see some of the people still hospitalized with serious illnesses. I live by Northside Hospital so it makes it easier for me. I put most of the patients in Northside so if I have to see them twice a day, I'm right there. I don't have to waste too much time traveling back and forth.

Z: Who reads those x-rays for the tuberculosis mobile x-ray unit?

K: At the present time, the members of the x-ray staff at the various hospitals take turns reading the x-rays. One doctor will read the x-rays for one month, and the next month another doctor will read the x-rays. It takes a little time to get the reports of these x-rays because they usually are busy with their other work. So, it might be a month to six weeks before they get to these miniature x-rays of the patient.

At the present time, most medical societies have decided that mobile x-ray should not be taken because these are x-rays really of a fluoroscopic image. The patient, getting one of these type x-rays, gets too much x-ray exposure. The medical societies, especially the American College of Chest Physicians, have decided that we should dispense with this type of x-ray procedure. If you take a regular type x-ray, using the regular 14 x 17 x-ray film, you get very little exposure. You can have, at least, one x-ray per year of your chest without causing any serious x-ray radiation problems. Not only that, but children of course should not be x-rayed in these mobile units. They are growing persons and you can get more injury from the x-ray radiation through a younger individual.

Z: How valuable would you say the x-ray units have been over the years?

K: Earlier, when we had a high death rate from tuberculosis, they were valuable. Even more so in the poorer neighborhoods, and the ghetto area. The American College of Chest Physicians feels that these units should be dispensed with and clinics should be set up in the ghetto areas where persons can get the regular types of x-rays.

Z: What kind of breakthroughs helped you in this type of medicine?

K: The biggest breakthrough in the conquering of tuberculosis was the discovery of the anti-tuberculosis drugs. These began soon after I left the tuberculosis sanatorium at Kirk Road. The first drug that was discovered was by Dr. Waxman, who discovered Streptomycin and this drug is

still used, but on a limited amount. The next drug that was discovered was PAS, which is Paro Amino Salicylic acid, and usually we'd use a combination of Streptomycin and Paro Amino Salicylic Acid. So that with the use of these drugs, very few patients then had to have surgical intervention. Then in about 1952, 1953 another important drug came out called the wonder drug for tuberculosis. This is Isomazid. This was a very cheap drug. I think 100 tablets only cost about 30¢ at that time. In fact, even at the present time, it's one of the cheapest drugs.

There are other drugs that are now used for tuberculosis. One of these is Rifampin, which was used in Europe for many years, before the Food and Drug Administration would permit us to use it. For the last two years, we've been using Rifampin in this country. Also another drug, that took a while to experiment with, is Myambutal. This has replaced the PAS, or Paro Amino Salicylic Acid in the past. So that most of these patients are treated immediately with a combination of Isomazid and the Myambutal or the Rifampin. Usually we use two drugs at one time. Sometimes if the patient is very ill with tuberculosis, we use three drugs at the same time.

Z: When you were at the Kirk Road Sanatorium, what were conditions like then?

K: When I first started there we had 170 patients. At the same time we had about 50 patients on the waiting list. Every bed, every nook and cranny that was available at the sanatorium was used for a bed. Even the recreation rooms and libraries were filled with a bed with a sick patient. Gradually as the drug therapy took over in 1946, the amount of beds diminished. We ended up with about 20 patients, I'd say, in the year 1969-1970. Of course, in the last year, we got down to maybe a single patient. Because of that we were forced to close the sanatorium.

Z: Why, because of the lack of new cases?

K: First, you're curing the people that had the tuberculosis, so that they are no longer infectious, and they do not give the disease to other people. Not only that, I think, we have a better climate in this country as far as people living better. They have better food, they don't work as hard. They're not pushed into these ghetto areas, where they come in contact with sick people. This climate has helped to prevent people from developing tuberculosis.

Z: Would you say there's a better climate of medical care for poorer people than there was in the 1930's?

K: I would say that the poor people, even at the present time, can get all of the medical care they need at both hospitals; Youngstown Hospital Association and St. Elizabeth's. The person that does not have the financial backing to pay a private physician can always go to these free clinics. He will be well taken care of. He'll get the best medical care because you can only give good medical care. There's just no so called mediocre care.

Z: Was it the same way back in the 1930's?

K: I think the patients at Cook County Hospital certainly got the best care possible. In fact, a lot of the politicians, rather than pay for a private physician, surgeon, or private hospital would come to the Cook County Hospital to be operated on there. They got the best care. If the politicians really got good care, then the patients certainly got good care.

Z: You were keeping everybody happy then. How about in Youngstown, would you say it was the same thing here?

K: In Youngstown there have always been free clinics at the hospitals to take care of these patients.

Z: Would you say people are more willing to go to doctors now?

K: I would say so. It seems to me that back in the old days, the only time you called the doctor was when the patient was dying. In fact, when I first started medical school, that was in 1931, the anatomy professor said, "Maybe some of you don't want to study medicine, because the average pay of a doctor is only $2,700.00." A lot of them did drop out of school, because they felt if we're only going to make $2,700.00, there's no use working. During the Depression a lot of doctors were driving taxicabs and doing pick and shovel work because they just weren't making any money. I worked with a young doctor who was sort of peeved with his family for putting him through medical school because he was working for $100.00 a month at a little hospital. That was back in about 1935. Then starting in 1938, it seems that the demand for medical care just skyrocketed. You just don't have enough doctors to take care of all the people that want medical care. A lot of these people have money to pay a doctor. Not only that, a lot of them have insurance paid for by these different manufacturers so that they are covered through their job. Payment is made to the doctor and the hospital. They demand medical care and that's why the medical profession now is so overwhelmed with just too many patients.

The medical schools just haven't been able to catch up on putting out the amount of doctors. We have over 200,000 physicians now. When I started, about 30 years ago, we only had about 140,000. So there has been an increase, but still it's not enough to take care of all the people. The towns that suffer especially are the smaller towns because after a doctor spends so many years getting his training, he just doesn't want to be locked up in a small town by himself where he has to be on call 24 hours a day, seven days a week. He likes to be in the bigger city, where he can get some relief from his colleagues.

Z: What would be the biggest reason why people started going to doctors then? Was it just because they had more money?

K: I don't think it's because they had more money, but because the medical profession had more to offer starting in 1938. When I was in medical school the formulary of the drugs in use was a very thin book. There was less than 100 pages. You could page through it within a day. At the present time the book we have has about 800 pages with the various types of drugs. Then the antibiotics came in, in the early 1940's. So with all of these new medications there's a lot more that you can do for a patient.

We started with the operation on the lungs and this was followed, later on, with operations on the heart. In fact I saw the first patient operated on with an open heart operation in Chicago by Dr. Charles Bailey. This was a meeting of the American College of Chest Physicians. He had operated on this young secretary who had a rheumatic heart and he had flown her in from New York, to demonstrate the good result that he had had. He brought her all the way to Chicago. It was the first open heart operation. Since that time, we have many heart surgeons that do nothing but operate on hearts. In fact, yesterday, I saw in the paper this Dr. Christian Barnard in South Africa did a special operation. He transplanted an extra heart from a dead person into this person that had a very poor heart. This patient now has two hearts. He has his own heart and also the transplanted heart. He has a spare heart. Of course Dr. Barnard was the first doctor to really do the heart transplant successfully. He was in a meeting, about three years ago, in Washington at the American College of Chest Physicians to give a talk on his particular procedures.

Z: Being a specialist yourself, could you provide any insights as to just when this started to happen?

K: I think the specialties really started in the mid 1930's, and it's just impossible for a single doctor to be a so called general practitioner. He can't do all of the surgery and all of the medicine. You just don't have that kind of a brain anymore, and you have to sort of limit yourself. Then when you limit yourself, you're the doctor that decided when he has to call in a particular specialist. There are certain things that you can do yourself, if you're a specialist in chest diseases. Then you really don't need to call in anybody in that particular field. But, you're seeing patients with other diseases and you have to decide when to refer these to other specialists. For instance, today I referred one of my chest patients, a medical patient, to a thoracic surgeon. This thoracic surgeon will bronchoscope the patient and if he needs lung surgery, then he'll have some lung surgery done by a lung surgeon. Occasionally it's necessary to call in a cardiologist that will catheterize the heart and get x-rays of the coronary artery. This is a new field.

Dr. Sones was the pioneer in this field at Cleveland Clinic. He would catheterize the heart and inject the dye into the coronary vessel. Because of this particular procedure, at the present time, many persons with severe coronary artery disease are having operations to correct this hardening of the coronary artery. Many physicians, in fact in town, have had this particular type of operation and they're able to continue working. They don't have the severe chest pain. Their chances of getting another coronary heart attack or acute heart attack are lessened by this particular surgery. So that's a particularly new field. There are a lot of physicians that went into that field and a lot of these doctors that would normally have gone into general practices are in these speciality fields. That's why we're short of so-called general practitioners. Personally, I don't think there's going to be too many general practitioners because most doctors want to specialize in some particular field, other than just try to play the whole field. It's just too much for one man to stand this particular type of medical practice.

Z: What do you see as a solution to that?

K: The only solution, I see, is that these groups of specialists must set up a clinic type situation. For instance, Cleveland Clinic has all types of specialists there. Even in town here, there are groups of physicians that have particular specialists in their group. I think within a few years, we're going to have clinics with these different type specialists in one building so that a person can be referred from one office to another, in

that same clinic setting. That way, you'll get the best care and you'll get the care through specialists in that particular field.

Z: Where does that leave the hospitals then?

K: Well, the hospitals still are going to have to take care of the severe cases that have to be hospitalized. I think we should be able to decrease the patients that are in the hospital that stay in the hospital. Because at the present time, I think, a semi-private bed is about $70.00, and a private bed is about $77.00 a day. This does not include the laboratory work or the x-rays. So if you add on the x-rays and the laboratory work, the first day in the hospital could cost you about $200.00.

Z: So you see more out-patient work.

K: Of course, because of my office and all of the facilities I have here, I can work up the patient before I send him to a hospital. So a lot of the extra work is avoided because it's already been done.

Z: So, it's basically a movement such as we had. The smaller hospitals moved to the big hospitals that have everything and now we're decentralizing again, is that it?

K: We're really trying to set up clinics without hospital beds, but just out-patient treatment.

Z: What were some of the other big killers?

K: Of course tuberculosis was one of the biggest killers, but at the present, the biggest killer is heart disease.

Z: Was that a big problem back in the 1930's and 1940's?

K: We had absolutely no treatment for heart disease at the time. If the patient developed a heart attack, why you just put him in a bed for three or four weeks, and hope that he would respond to the bed rest. Many of the patients, especially in the hot months of the summer, with their heart disease would just pass away. You'd lose maybe a dozen patients within several days of this hot weather, but even when I was at Cook County Hospital, the first diuretic was started. Since then we've had a lot of diuretics that is used for failing hearts.

People that develop this swelling; the edema of the ankles, the edema of the liver, and the edema of the lungs, with the use of these various diuretics, we can get rid of the excess water. We can bring the patient back to a fairly normal state. At that time, the condition was known as dropsy and anybody who had dropsy meant that he had a failing heart with the accumulation

of fluid throughout his body. When a doctor ever mentioned dropsy to a patient, he knew that he was in serious trouble and the family always felt that this patient didn't have too long to live.

With these various diuretics now, we can really treat this condition adequately. Also in hypertention, up until a few years ago, there was very little medication we could offer patients that had high blood pressure. The only thing you could do was to put them on a little sedation. Most doctors thought that high blood pressure was due to a case of nerves. Now with the various antihypertensive drugs these patients are well controlled. You prevent strokes, heart failure, and the failure of the kidneys. So here's a field where, just in the last few years has increased so that, again, more patients are being treated and of course, more doctors have to treat these patients.

Z: How long does it take for these various advances? You were in Chicago, how long does it take for them to get to a town like Youngstown?

K: It doesn't take too long, because most doctors attend these medical meetings. The American Medical Association has two meetings a year, then the specialty groups have a meeting at least once a year. They have a lot of post graduate courses. I know the American College of Chest Physicians has a post graduate course almost every month in some part of the country. Most physicians will attend either the meetings or the post graduate courses. They listen to the lectures, pick up this newer science of the treatment of patients and the newer medications. It spreads pretty fast because of the various medical meetings. Of course doctors are forced to attend these meetings. You have to keep abreast of the times because a lot of the medications that we used back 30 years ago, are no longer used. You have to use the newer medications that really do the work for the patient.

Z: How often have you gone to these meetings?

K: I just came back from New Orleans: I was at the meeting of The American College of Chest Physicians. We had a four day meeting. Of course, we discussed all of the different treatments for not only the medical lung diseases, but also the surgical lung diseases. I attend meetings usually about twice a year, besides attending the regular hospital meetings.

Z: How long have you been attending these meetings?

K: Ever since I graduated from my medical school. I think most doctors do.

Z: How about pneumonia, would that be a serious disease?

K: When I was an intern at Cook County Hospital, we had a so-called pneumonia ward. All patients that had pneumonia were put in this particular ward. They were given oxygen because most of these patients were very short of breath. About 1937, a new drug was discovered in Germany called called Sulfanilimide and this was the first really anti-biotic that was used in these pneumonia patients. Many doctors felt that this was too toxic of a drug to use, but we had to try this particular drug on these pneumonia patients and it did help some of these patients. Soon after that, we had a discovery first of penicillin, in England. Of course, this really helped to treat the pneumonia. It seems since the advent of penicillin and some of the other broad spectrum antibiotics, we haven't had too much pneumonia. In fact you don't have the severe type of lobar pneumonia. Very well persons would suddenly become sick, develop chills, a high fever, a cough, and they couldn't breathe; you don't have this type of pneumonia anymore. The type we have now, is called bronchial pneumonia, where it's sort of scattered throughout the lungs. Many of these cases, if they're diagnosed early can be treated as really home patients. You see them in the office, take an x-ray, see the disease, and give them prescriptions for the various antibiotics. Within a period of three or four days, the pneumonia has cleared; you take a new x-ray and you see the complete clearing of the pneumonia. Very few people at the present time die of bronchial pneumonia.

Z: That's quite an advancement.

K: Yes, it is.

Z: Were there any remedies for the common cold, other than what we have today?

K: The only remedies they had at that time, was to use aspirin, hot tea, and that's about all. Even at the present time, for the common cold, there really is no particular treatment. You decrease the morbidity, that is how long a person is going to be sick. If he should develop complications, such as a severe infection with high fever or an infection in his ear, then we have the antibiotics to use to sort of work on the secondary infection.

Z: Did you ever have any problems with anybody taking their own home remedies and giving you a problem?

K: There are people who still believe in taking their own medications and a lot of people are allergic to even plain

aspirin. A lot of these people take aspirin and get severe pain in their stomach, break out in hives, or they develop an edema of the larynx. Of course, right away they seek the doctor to see what is wrong.

The Food and Drug Administration, at the present time, has restricted almost all of the drugs that are dispensed so that a patient just can't go to the drug store and order a medication. There are certain ones, such as laxatives and aspirin can be obtained. When it comes to sedatives, tranquilizers, and so forth, you are unable to obtain these without a doctor's prescription. Even the doctor's prescriptions are limited. He can have one or two prescriptions and then he has to get a new prescription from the doctor to get it refilled.

Z: Did people try to do anything to treat the symptoms of tuberculosis before they came to a doctor?

K: I had one patient who listened to one of these faith healers. She evidently had listened over the radio and she said she had been cured. In fact, she ran in here one day and said, "Would you mind taking an x-ray of me." I said, "What for, I just x-rayed you last week." She belonged in a sanatorium, but she wouldn't go. She said, "Will you x-ray me and I'll tell you why I want a new x-ray." So I x-rayed her and of course the disease was just as bad as ever. She said, "Well, the reason I wanted the x-ray is because this faith healer said I am now healed." That patient refused to go to the hospital and she died within a period of about two months. There was no way to force her into the hospital because she didn't believe in medical care, she didn't believe in medicines and she just decided that she would take care of herself, and rely on these faith healings. This is a bad thing to rely on a faith healer rather than science to take care of the disease where you have medicine that can cure the disease.

Z: Has this increased or decreased over the years?

K: You mean the faith healing?

Z: Yes.

K: Well, if you listen to the radio or television, there's a lot of faith healers on. There's nothing that the country can do or the Food and Drug Administration because people will listen to these faith healers and they believe in them sometimes. They just don't go to the doctor that they should see and get really a decent examination and treatment for what ails them.

Z: Have you ever had any face to face confrontations with any people like this; the faith healers?

K: No, I haven't.

Z: You never had a chance to argue with them?

K: No.

Z: Have you ever performed any house calls?

K: Yes, I still make a few house calls because I still have some older patients that can't get around. Most of these house calls are on acutely ill persons. When you take the telephone message you can decide whether that person is sick enough to go to the hospital. It's better for the doctor to listen to whoever is from the house of where the person is ill, rather than the nurse to take the message. Usually, you can tell if a person is sick enough to be hospitalized or whether you should go over and make a house call. It's foolish to make a house call and then just tell the patient, "You're sick enough and you belong in a hospital." It's wasting the doctor's time and the patient's money to make a house call to tell him he belongs in a hospital. A lot of these patients are told that they're sick enough, they belong in a hospital, and they wind-up in a hospital. Now most of the other patients, if they're not too sick, can always come to the doctor's office. With the transportation the way it is, everybody has a car and it only takes a few minutes, especially in Youngstown, to get to the family doctor, have him check you over, and then he decides on a treatment.

There aren't too many house calls being made. When I first started I used to make calls day and night. When you make a house call at 3:00 or 4:00 in the morning and then have to be at the office at 9:00 in the morning, you're pretty well tired out. It's just asking too much of the doctor to work hard all day in his office and then run around in the evenings making house calls.

It just takes too much time. By the time you get there, it may be 15 or 20 minutes, then you examine the patient, another 15 or 20 minutes. It takes about an hour to make a house call. The doctor just can't afford it. In his office he can see 5 to 6 to 8 patients in that particular time. He has all of the instruments available. For instance, if I want an x-ray of that patient's chest I've got the machine right here. If I want an electrocardiogram because I'm afraid they have had a heart attack; I take the electrocardiogram and immediately can tell them whether they've had a heart attack or not.

Z: When you were on staff at the sanatorium, were you on call 24 hours a day?

K: I was on call 24 hours a day and they would just call whenever they needed me.

Z: Did you live over here?

K: No, I had an apartment right inside of the sanatorium, so that if they wanted me, they could just reach me.

Z: Were you a family man then?

K: I was a family man. We had one child and it was a little rough then, my wife lived down the street. That's why I only stayed six months because there was just too much work. There were only three of us. We had a woman physician help some, but she usually wasn't on call because she was up in years herself. Dr. Kirkwood was the other doctor and he didn't take any calls because he just worked days. He lived in town. It was up to me for those six months to really work 24 hours a day, 7 days a week.

Z: Did they increase the staff after that?

K: Yes, after that they increased the staff. They hired somebody from North Carolina and he immediately brought in several other doctors. He didn't stay too long either because he was disillusioned with the job. He thought he was working a little too much. There were 170 patients to take care of. Even in a smaller town like this, you just couldn't get enough chest disease specialists to take care of the patients.

Z: During the 1930's did you have any problems collecting your fees?

K: In the 1930's I really wasn't in practice; I was still a medical student. I was in the Depression, so I lost two years of medical school because we couldn't borrow a dime and we couldn't earn a dime. The only thing to do was, you had to drop out of medical school unless you could come up with the tuition. These schools just wouldn't have you. At that time the government had no loan programs for students. I had to drop out for two years and then when I got back I was able to get this first-aid job with Youngstown Sheet and Tube. That put me through the last two years, plus this one year of fellowship in the medical school. Most students only spend four years in medical school, but I spent five because of this extra fellowship year. They paid you $750.00 to be a fellow for the whole year. At that

time money went further. Even working at this first-aid job we were getting $100.00 a month which was a good deal of money at that time. Of course, now $100.00 doesn't mean very much. This inflation is terrible. My tuition at medical school, at that time, was $270.00 a year. At the present time, I understand, they're charging $2900.00 for tuition at Loyola Medical School. They have a brand new medical school and I think they spent $70 million dollars to build it. It takes a lot of money to go to medical school anymore. In fact, when I went to Loyola they took 150 students in the Freshman class, but at the end of the sophomore class they expected to flunk out 50 of these students. They felt that they would just pick the cream of the crop, so that only 100 students would really become doctors and the other 50 were just out of luck because they couldn't make the grade.

This isn't the case at the present time. Medical schools, now, take so many medical students and because of their good choice, expect to graduate every one of those students. In other words, they're not looking to flunk out one-third of the class. If you really apply yourself as I say, hey choose the students that are the best students so that very few will drop out because of their academic deficiencies.

Z: Could you fill us in on the development of the pre-med program in Youngstown?

K: I got in on sort of the ground floor, because the school really started in about 1929. Dr. Worley was the head of the Biology department and I knew that right after the war they were looking for part-time teachers. I had a Masters of Science degree and I volunteered to start in the second semester of 1947. Of course, I was instrumental in getting some of these students into medical school. At that time, with the students returning back from the war, there were a lot of students trying to get into medical school so it was hard to get in. If you had some alumnus of medical school speak for you, you were able to get into medical school. So we did get a few students from Youngstown into Loyola because of the fact that I was an active alumnus. We kept up the pre-medical program, and now with this new medical school starting in this area we'll have students that will go directly into medical school.

Z: Are they going to establish a pre-med department here?

K: It's going to be a little different because it's going to be a straight medical department. As soon as you're accepted into the program, after high school, you are in the medical school. In fact, my son went to North-

western University just graduated about four years ago, and he was in the so-called six-year program. There are only twenty-five students that they take every year in this program. As soon as he was accepted when he graduated from high school, he was in the medical school program. He had two years of pre-medical work at the Evanston campus, which is north of Chicago. In the next four years he was at the downtown medical school. So he was really a part of the medical school for his full six years, rather than just taking pre-med and hoping that he'd get into medical school. It's a better way to work it and I understand schools in Canada do the same thing.

In other words, as soon as you leave high school, depending on your average grade and your aptitudes, they accept you into a medical school program. So the first year you're in college you know that you're going to be a doctor because you're already accepted. You don't have to worry about after you're pre-med about 3 or 4 years, whether you're going to be accepted by the medical school. I think it's better that way and we should come through it nice. Of course, at the present time, most medical students have four years of pre-med. They're trying to cut that down and a lot of schools have gone down to three years and many of them have gone down to two years.

I had a two year program which was good enough. I think the reason they should cut it down is because so many of the doctors, after they graduate and finish their internship, want to become specialists and this takes anywhere from three to five years. So, if you spend all four years of pre-med you're at lease 32 years old before you're ready to make a living. So it's better to cut down on the pre-med and add it on to the specialty training program.

Z: Back in 1948, what kind of courses were offered?

K: We had the regular biology courses. You had your early biology, the insects, and the worms and so forth. Then we got up into the cat anatomy and then we had the physiology. Of course we had Physiology I, which is more of the human anatomy course; then we had Physiology 2, which was chiefly a physiology course. We then had Histology, which is making slides of tissue for microscopic study. Of course, all of these students had to have a course in physics. Usually the engineering-type physics is just a little too hard for the pre-med students because they don't have enough mathematics. So they set up a special physics program for pre-med students and all pre-med students have to have chemistry. They have inorganic chemistry, organic chemistry, and

usually they have a course in physiological chemistry. Those are the main courses that a pre-med student needs. He has to be given physics, biology, and chemistry because he's going to use that the rest of his life.

Z: Have the students from Youngstown always had pretty good luck in being accepted?

K: Yes. We have students that have gone not only to the regular M.D. schools, but to the Osteopath schools, the Veterinary schools and to the Dental schools. Even in this town, there's a lot of my students. In fact, Dr. Melnick happens to be one of my students. He was in pre-med in one of my classes. He's one of the doctors that got his pre-med training here at Youngstown State University.

Z: Who were some of the associates that you had in your first few years?

K: You mean at the university?

Z: Yes.

K: Dr. Worley was head of the department then. He evidently had been doing a lot of research for a drug company. He was asked to come here by Dr. Howard Jones and took a terrific cut in pay. He took the job to head the biology department. Of course, he felt that he was doing a good thing. He wasn't interested in how much money he could make, but in just how much good he could do. He was really a wonderful professor and he not only taught biology, but he was quite a whiz in mathematics courses. We had Dr. Marcy who passed away rather at an early age. He developed one of these endocrine diseases. He was one of the mainstays of the department.

Dr. Inga Worley (Ph.D.) who was Dr. Worley's wife, was also a doctor of philosophy. She taught there until about a year ago. She was chiefly concerned with the plant part of biology, the botany. Those were the main ones. We then had Dr. Van Zandt, who is now the head of the biology department. He's been there for a good many years. Mr. Sturm has been there for about five years. He's a very dedicated person. You see him not only in the daytime, but he's there most evenings helping with classes and research work.

Of course at the present time the department has increased in size. There are a lot of younger men. I can't keep track of their names, but they're doing a lot of research work. If you look in these various laboratories, you can see all of the new equipment. In fact, we're sort of crowded for classroom space because they're moving in all

this research equipment. They have an animal room with the mice and the rats that they work with.

Z: Who were some of the other doctors in town at this time?

K: Of course, there's a lot of doctors that have come and gone.

Z: Well, some of the ones you've associated with.

K: The ones that I worked with was of course Dr. Kirkwood, who was the first director of the Tuberculosis Sanatorium. He passed away about 10 years ago and Dr. Joseph Keogh passed away. He was the first thoracic surgeon in Youngstown. We had Dr. Piercy who was an ear, nose and throat man. His son became an ear, nose and throat man, too and he helped us out at the Sanatorium. A lot of these specialists would come out there to take care of patients for their particular non-tuberculosis diseases. They would come out without expecting any pay and usually they would set aside a morning or an afternoon to come out.

Dr. Fuzzy was a rectal specialist and would come out about once a week to take care of the rectal problems of these patients. Dr. Malkoff, a dentist, took care of these patients with their dental problems at the Sanatorium for as long as the Sanatorium was there. In fact, he worked until the Sanatorium closed. Those were the main men in this particular field.

Dr. Testelbaum was at the Sanatorium as the medical director and again he passed away suddenly from a heart attack about six years ago. He was a very dedicated man, and he was a straight tuberculosis specialist.

Z: What else do you know about some of the early medical history in Youngstown.

K: I know that when St. Elizabeth's was started it was rather a small hospital. In fact it was really just a house. They started building the main building which is now the old building; they're thinking of discontinuing bed patients to that particular building. Over at South Side, we had what we called the cottage type of rooms. They were just one-floor wards containing up to 40 patients in each ward. Of course, that was dismantled and the newer part added to it. There are a conglomeration of buildings at South Side Hospital because of the new additions. Even now, they're adding a new addition to the hospital costing about $16 million dollars. With this $16 million, I think there are only

125 additional beds. Building is very expensive because of the inflation at the present time.

We should have about 600 beds at South Side Hospital and about the same amount at North Side Hospital. At the North Side Hospital they expanded in that they built the Northwest wing several years ago. They took over the Tod's Nurse's Home and made that into a pediatric hospital. That was a very expensive deal, too, due to inflation. When they started out they thought they'd spend about $750,000 I think they ended up spending about twice that much to get the place built. Building the hospitals is really an expensive proposition.

Z: When did the Tuberculosis Sanatorium open?

K: That opened, I think, in 1927. It closed last October. The building is lying dormant there. They don't know whether it can be used for anything now. When it was built they didn't put lavatories in each of the rooms, so there's just a common sort of lavatory area. The rooms are rather small because they tried to isolate patients by themselves in each room, so they built small rooms. I doubt if they'd ever be able to use it again as a medical facility; even as a nursing home. In fact, there are so many restrictions on nursing homes now that they want them to be at least as good as hospitals.

Z: Are there any reflections you can give us about your experiences in Industrial Medicine, when you worked in first-aid?

K: In industrial medicine you can see that you're really doing something. When a patient gets hurt, he cuts himself, his finger, or breaks a leg, you can immediately take care of the situation. Even when I became a chest specialist in Youngstown, I worked for the Youngstown Sheet and Tube for about ten years as a chest disease specialist. At that time we were x-raying every patient, and every employee that came for a job. Of course, we'd look at these x-rays to see if they had any lung disease that might be aggravated by working in the mill. If they did have such a disease we would just tell them they shouldn't work in the mill. Of course, the company wouldn't hire people that had particular lung diseases. I think in those ten years I read, at least, 60,000 chest x-rays of the various people that were seeking employment. After the war we were examining anywhere from 50 to 75 employees everyday, that would come for a job. When these people would be sent into the mill they would look around to see what type of job

they were assigned to. Some of them wouldn't even start; they would just walk out because they just didn't like that type of work.

I did take care of the Columbiana County Tuberculosis Clinic for about 12 years, too. That's just south of here. They had no sanatorium and they needed an out-patient type clinic. So I set up the out-patient clinic. Most of the patients there beginning in about 1948 were treated as out-patients. In other words we had the medication and we gave it to them. We had a staff of nurses that made house calls on these patients. They'd go out and see the patient maybe once or twice a week, give them their streptomycine shot, see that they had their medication, take their temperature, and then about every three months they would be brought into the clinic at the courthouse. We'd get a chest x-ray to compare the progress of the disease with their previous x-ray. At that time we had some patients farmed out to other sanatoriums, chiefly Ohio State University. We had a tuberculosis division there. When we had a real sick tuberculosis patient he would go to Columbus. We would visit him about every three months. When he was well enough to come home, we would take care of him at the Columbiana Tuberculosis Clinic. About seven or eight years ago, when I left there, we only had about eight patients in the sanatorium. The rest of them had been cured or they were well enough to be treated as a home patient, coming to the clinic for their medications and follow-ups.

Z: Who paid for all of this?

K: Columbiana County had a tuberculosis levy The levy paid the doctor's salary, the salary of the nurses, it paid for all of the medication and for the x-rays.

Z: How about Mahoning County?

K: Mahoning County also has a clinic. Patients that can't afford to pay for medication and x-rays aren't charged. Those who can afford to pay are required to pay for their medication. There is a minimal charge for the chest x-rays.

Z: How was the sanatorium built. Was it built with public money?

K: That was built with public money. There was a bond issue and it was built in 1927. Before that time, I don't know where the patients went, but starting in 1927 that place was jammed. Right from the beginning until we started to get the medication for tuberculosis, it was crowded.

Z: How did they get money to run it then?

K: There was a tuberculosis levy. Every five years there would be a renewal of the levy and all the people paid. I think it only amounted to a family paying about $3.00 or $4.00 a year to keep the sanatorium opened. Which is cheap because you were isolating the infectious cases in the sanatorium and that way you were protecting yourself and your own family. Otherwise these cases would be running all over town.

Z: Did most populated counties have a sanatorium?

K: Most populated counties did have a sanatorium. The smaller ones didn't. Most of them at the present time are closed. I think Cleveland, Toledo, and Cincinnati still have one open. The rest of them, I think, are just about closed; even Columbus closed down.

Z: You've worked for government agencies and you know a little about them, do you have any reflections on that?

K: There's an awful lot of paper work. We have Medicare and Medicaid now. I don't know who devises these various forms, but I know this one public welfare sheet must have had about thirty different blocks that you have to fill in. I think just a simple billhead with just the diagnosis, the treatment given, and the charge would be adequate to take care of it.

The Veteran's Administration started and I took care of a lot of veterans since I started practice. I even have a group now. At the beginning they had very complicated forms, but in the last ten years or so, if you take care of a veteran, it's a service connected case. You use your own billhead, put down his name, claim number, diagnosis, what you treated him for, and what your charge is. You send that in an envelope up to the Veterans Administration in Cleveland and within the month you get paid. You don't have to fill out these complicated forms that are really impossible to figure out. No matter how many girls you hire, they just can't figure out the forms. In fact, I can't figure them out myself. So we keep getting these forms back, saying you didn't fill in this right or you didn't fill in that right. It's just too complicated. In fact, they ask you to come to Columbus so they can explain the forms to you. Why should they be? They should explain it in a letter or make it simple enough so you don't have to have a person travel all the way to Columbus to get an explanation on how to fill in a medical form. I think it's going to get more complicated and I don't know what to do with these sheets of paper. I know when I fill in some of these papers, there's seven or eight copies and it's impossible to see the last copy. You can't see the

writing because you just can't press your pen down hard enough to push through that last carbon copy. I don't know what they do with them, they must just stack them up. It must take acres and acres of storage space to keep those papers. I don't know what's going to happen.

Z: You mentioned freedom of the doctor was one of the reasons you went into medicine. Has it changed any?

K: At the present time, I think most doctors are still free to practice the way they want. Whether we're going to have socialized medicine in the future is hard to say. If we do, I think we'll all be sort of regimented; told what to do, what to charge, how many hours to work, or how many patients to treat. At the beginning, when I was treating these tuberculosis patients, they limited me to the amount of patients. Even though I was the only doctor doing that type of treatment in this area. They wouldn't pay me over and above what they said they would allow me, so I treated a lot of these patients free; I just didn't get paid. Whether this new government system is going to do that, I don't know. If it is, it just means that the doctors are going to limit their practice and just take care of so many patients.

I think the patients will suffer because there won't be any medical care. Even now, with this high income tax, a lot of doctors just aren't working as hard as they used to because the harder you work, the more money you make and the money goes back to the government. Instead of making more money, they're just taking extra time off from their practice.

Z: When you were back at Cook County, was that a type of socialized medicine?

K: It was all free medical care. The person just came in and said, "I'm sick," and they were treated.

Z: You didn't have any forms?

K: You didn't have any forms, they just signed in.

Z: Did you have pretty much a free hand. . .?

K: That's right. You wrote a history and examined them, made a diagnosis, and the attending man would come around and help you with the diagnosis. You'd prescribe the medication and treat the patient.

Z: Do you see that happening again on a nationwide scale?

K: There's so much Medicare and Medicaid, aid for the aged, and aid for the disabled. Even Cook County, now, doesn't have charity patients anymore because they can afford to go to a private doctor. He's going to get paid from the government. The hospitalization will be paid for by the government. So where we had indigent patients before, we're not having them now. As soon as you are sick for two years, you get on the dole that you're an aid for disabled person. Then the government takes over your responsibility.

In other words, you're going to have socialized medicine. It's going to cost billions of dollars and I don't know where it's coming from. I think we're going to go bankrupt if it really goes through the way they want it to go through. Maybe we'll have a lot of neurotics coming through the office. So I don't know how you can treat the sick people and get rid of the neurotics. It's just going to take up an awful lot of time. I suppose doctors are going to have to neglect some of their really sick patients in order to treat these neurotic patients.

Z: In all your years of practice is there anything that you would've liked to have changed?

K: I don't think there is. I've been rather busy. I've enjoyed my practice. I don't expect to ever retire unless I should get sick. In fact most doctors don't retire, they just like the practice of medicine, they like to take care of sick patients, and they like to see them get well. They like to see them get back to work. I suppose that's the reason you don't see very many doctor's coming right out saying, "Well, I'm retiring. I've had enough." They just keep right on going

Z: Do you see the young doctors being the same way?

K: I don't think the young doctors work as hard. They usually set up in groups. They're on call for each other. They only work maybe every third or fourth weekend. Even if they're in town, their telephone service says well, "He's not on call today. So and so's on call, call him." Of course I talked to one young doctor and he says, "Well, when I get to be 65, I'm going to take my social security and that's going to be it." I don't know if he's going to change his mind when he gets to there or not. The older doctors still work long hours and they just don't feel like they should ever retire.

Z: You were talking about the students that are going through the pre-med down here at Youngstown, do you see them like this; is their attitude the same?

K Well, usually when you have pre-medical students they're the higher type of students. They work a little harder than say students in Social Science, History, or Geography. They have to take sciences which are a little harder to deal with. You really have to use your brain. They are a little different breed of students when it comes to studying. They put in long hours and they don't engage in too many extracurricular activities. They really hit the books. Of course they have to hit the books because you have to have a point average of about 3.5 before the medical school will consider your application. They look at that first before they even look at any of your recommendations from doctors or anybody else. You have to have the grades in order to get into medical school.

Z: Have you seen any change in the attitude of the students?

K: No, they're still hard working students. They've made up their minds that they want to get into medical school. They are willing to put in the time and the effort to really get good grades so that they can be accepted into medical school. I tell them, I know right off the bat, you're not going to get in by a lot of pull. You have to have the grades and you might as well settle down and really get the grades.

Z: Which do you enjoy more, teaching about medicine or practicing medicine?

K: I enjoy both. I'd hate to give up the teaching. It would be easy enough to quit those two nights a week and be at home now taking it easy. I like to be with the students to give them a hand and hope that they get into medical school. Of course, I see a lot of these doctors, dentists, and veterinarians that I've had in class that are now in practice.

Z: Well, thank you very much Dr. Kravec.

K: You're very welcome.

END OF INTERVIEW