

“I’LL GET TO THE BOTTOM OF THIS,” WARNED DR. R.

In the early ‘50s, while José was Chief of Nuclear Medicine at the VA Hospital in Philadelphia, there existed a rotating cycle of consultants. Every three months, the Chief of Nuclear Medicine from one of the five medical schools that had a professional guidance capacity at the VA Hospital would come to consult. (This consulting took place once or twice a week, and consisted of a one to two-hour review of what the patient activities were.) The medical schools involved at that time were Temple, Women’s Medical, University of Pennsylvania, Hahnemann, and Jefferson. Pay to the consultant was \$75 per visit, regardless of the length of time spent. Once in a while, the time spent would be less than fifteen minutes, while, occasionally, it could be two hours. The consultant would come to the Chief of Staff’s office and sign in. When he had concluded his visit, he would return to this office to sign out.

On many occasions, a very important person would call and suggest that José come to his office at his hospital, bringing patients’ charts along, since he himself did not have time to make the trip. José would explain that the consultant could not get paid without the entrance and exit signatures. Then, immediately, the consultant would find the extra time to appear. Occasionally a consultant would suggest that José sign him in and out, also hinting that he would “owe” José a favor. Each time, José adamantly refused. This request was later made by one of the deans, putting José in the embarrassing position of having to refuse.

Every three months, with the arrival of the new consultant, dosages given to the patients (for radioactive uptakes, scans, and/or treatments) would be changed. The consultant of one medical school would refuse to accept dosages and treatments recommended from the previous medical school. This resulted in extra work for José.

When Dr. R. from Temple refused to accept results from the radioactive measuring equipment that had been purchased at the suggestion of another medical school, José spoke to the Director of the VA Hospital, who suggested having whatever equipment and dosage had been requested for each medical school. Dr. George Clammer explained to José that the Pharmacy Department kept five separate stockrooms with medications because one medical school would not accept the medications recommended by any of the others. The operating room proved to be a major problem. Anesthetics were rotated regularly to satisfy each medical school as its turn came up.

José obtained the funding to purchase some of the measuring facilities as requested by Dr. R. from Temple, who refused to accept results from the uptake machines and scanners that had been recommended by another medical school. Fortunately, for some reason, only two sets of facilities had to be maintained at the

Nuclear Medicine Department rather than the five in Pharmacy.

One day Dr. R. arrived and began screaming that the elevator to the ninth floor (where the Nuclear Medicine Department was located) had not been available for close to ten minutes. He had had to stand with a group of patients waiting for the elevator to arrive. José suggested that he report this problem to the Director rather than to him, since he had no control over the elevators.

On the next visit, Dr. R. threatened not to return as a consultant, and warned that he would withdraw if this problem continued. Apparently, the Director had told him that many a time at Temple University Hospital, the same thing had happened to him. Dr. R. now told José, "I'll get to the bottom of this!"

Months later, a patient that had thyroid metastasis required a large dosage of radioactive iodine for treatment. José called Dr. R. for advice. Dr. R. said that he would have to come in for a visit to see the patient and to get paid. Soon after arriving, he agreed with José's calculation of the dosage. Ten minutes later, he left. José then had to see the Director and the Chief of Supply because, at that time, the cost of the radioactive material was very high, and he required special permission. Also, the drug had to be ordered directly from Oak Ridge and shipped in a special extra-heavy lead container. He carried out the paperwork and orders, and the shipment soon arrived at the hospital.

José then called the patient and explained to him what would occur. The patient refused to take the dosage, stating that he had read somewhere in a popular magazine that large doses of radioactivity could render him impotent. Lengthy chats from José and several other members of the hospital staff failed to convince him otherwise.

José called Dr. R., who told him, "I'll get to the bottom of this!" and requested another consulting visit. Of course, the patient still refused, and all the isotope material had to be carefully stored until it decayed, which took several months.

Months later, Dr. R. returned for a new visit. This time, he brought with him a young male technician. José immediately recognized this fellow as Barry Greenberg. Barry's face was completely covered with white pustules of pus that extended all the way down to his neck. Dr. R. told José, "We have to let this man go from Temple Hospital. I would like you to hire him immediately."

José remembered the technician as a student from Philadelphia College of Pharmacy and Science, notorious for unusual behavior and his complete lack of civility. Dr. R. now wanted to know why José was delaying bringing out the paperwork to begin the hiring. In talking to the young man, José was able to extract the information about why he was being downloaded at Temple. Apparently, the laboratory had an NIH grant to investigate some uses of isotopes, and this technician had found that some ordinary reagents, when the level of the contents of

the bottle came near the bottom, would be poured down the drain, since no storage space was available in the laboratory. No hazardous materials were involved, but this young man had calculated that, in the six months he had been working there, 20 to 30 dollars' worth of materials had been poured down the drain. He felt that he had to notify Washington of this because of the grant, which he did. He believed that he had saved money and should be rewarded. NIH sent an investigator to Temple, and concluded that the materials disposed of had been non-hazardous. He concurred that the only reason the remnants in the bottles had been disposed of was for lack of space in the laboratory.

José explained to Dr. R. that Civil Service regulations prevented him from hiring anybody directly. This young man, he explained, would have to apply to Civil Service and wait for an opening (which at that time did not exist) in José's laboratory. Dr. R. glared at José and told him that he suspected something was amiss. He himself, he threatened, would get to the bottom of this immediately. With this, he stomped out the room, followed by the young technician. José later heard that Dr. R. was no longer available from Temple. Another physician from that school had replaced him.