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Boston University
How Goes The Battle Against Heart Disease?

A special report on research and treatment
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**Letter from the editors**

Much media attention has been paid in recent months to several dramatic organ-transplant cases. With the increasing skill of medical professionals and the use of medications that more effectively combat rejection of new organs, transplantation has become a more realistic option for some heart patients who otherwise would die.

As our cover story points out, however, in the vast majority of heart-disease patients, the ability to win out over the disease and to live productive lives depends upon a host of procedures, medications and behavior changes that are far less dramatic than transplantation. We can compare the relative value of transplantation with the value of other, less spectacular, advances by looking at statistics: In 1982, the last year for which federal figures are available, some 56 Americans received heart transplants; in the same year, at least 130,000 other Americans—who a decade ago would have died of heart disease—survived.

No single institution or investigator can be credited with this dramatic cut in the heart-disease mortality rate. What has brought medical science to this point of improved odds is the thousands of small battles being fought each day by medical centers—in patient care, education and research—and by an increasing number of Americans who have become convinced that their lifestyle choices can affect their chances of developing heart disease.
UNIVERSITY HOSPITAL
at Boston University Medical Center

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About University Hospital
University Hospital, founded in 1855, is a teaching hospital of Boston University School of Medicine. The Hospital provides a full spectrum of medical services. Its 379 beds include many special-care units, including psychiatry, coronary care, metabolic, medical intensive care, surgical intensive care, the New England Regional Spinal Cord Injury Center, the Wald Neurological Unit, the Respiratory Care Center and the New England Male Reproductive Center. University Hospital, Boston University School of Medicine and the University's Goldman School of Graduate Dentistry constitute Boston University Medical Center.

Cover: Cardiologist James Rothendler, M.D., (dark profile at right) makes calculations on a computer screen as he examines picture of a patient's heart chambers. Physicians involved in the treatment of heart disease have an increasing number of tools and techniques that allow them to visualize such functions as the contractions of the heart. In this case, the ability to look into the heart is provided through a process called digital videoangiography, which brings together technology that has developed in the fields of television, image intensification and digital electronics. The picture of the heart chambers displayed here on the computer was taken in the UH Cardiac Catheterization Laboratory after dye was injected into the patient's heart chambers. By employing this form of computer processing, the physicians can use a much smaller amount of the dye than is normally required. Story, Page 8.

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By J. Scott Abercrombie Jr., M.D.

Hospitals, particularly the academic medical centers, have been portrayed as big spenders who must be firmly leashed. The hospitals, are perceived by some persons in government and industry, and even among the public, as not caring enough about making health care more cost-effective.

In fact, though, most hospitals are very much concerned about the cost of care.

An example is the initiative by 25 hospitals across the nation, including University Hospital at Boston University Medical Center and Massachusetts General Hospital, to develop more cost-effective systems of quality care for the “at-risk elderly.” The effort is being supported by the Robert Wood Johnson Foundation of Princeton, N.J.

The at-risk elderly, are among the nation’s most costly health-care consumers. The elderly make up 11 percent of the nation’s general population; their care requires 29 percent of all health-care expenditures.

The “at-risk” designation speaks volumes about the state in which frail elders find themselves: They must cope continuously with the limitations of age, multiple medical and social problems, bare-bones incomes and, in some cases, unremitting solitude.

Many do not receive the proper kind of long-term care. Most older people do have access to the health system, but all too often only for costly acute care that could have been made unnecessary by earlier medical and social intervention; still others occupy acute-care beds when they should be in less expensive and more suitable care settings.

Our society has the tools and the expertise to do more for the elderly who are in need. And it is increasingly apparent that what they need is access to a tightly coordinated range of care, from hospital admission to homemaker assistance. Those individual services all exist today, but the continuum—the linkage—too often does not exist.

Providing that linkage is what the Robert Wood Johnson Foundation initiative is all about.

An example of such a system of managed care has existed for more than a century in Boston: Through a program called the Home Medical Service, University Hospital and Boston University School of Medicine have been delivering care to the city’s housebound for 109 years. The physicians, nurses, social workers and medical students of Home Medical currently care for 900 elders in the South End and other neighborhoods.

Home Medical has found that providing managed care in the home—and utilizing only when necessary the services of nursing homes, rehabilitation units and hospitals—can be effective in terms of both outcome and cost.

Another example is the excellent nurse-practitioner program operated by Boston’s Department of Health and Hospitals. Based at several neighborhood health centers, it provides services for such patients at home and in nursing homes.

The work that Home Medical has been carrying out stands at the center of University Hospital’s initiative under the foundation grant: Home Medical is providing to those elderly persons who are at a high risk of institutionalization a comprehensive service that integrates home-delivered and inpatient medical care, backed by community-based nursing, personal care and social services.

The agencies involved in the program with University Hospital are the Visiting Nurses Association of Boston; the Labouré Visiting Nurse Service; and the three Boston Home Care Corporations—Southwest Boston Senior Services, Senior Home Care Service, and Central Boston Elder Services. Also involved are two institutionally based programs: rehabilitation at Jewish Memorial Hospital in Roxbury that is aimed at returning the patient to independent living, and short-term respite care at Resthaven, a Roxbury nursing home.

University Hospital hopes that the program, begun in January, will lower demand for hospital and nursing-home beds, improve the quality of life of the elderly patients, and do so at a lower overall cost.

Since hospitalization is the most costly component of the health-care system, all long-term care efforts should be aimed at keeping the elderly patient at the most appropriate level of care—be that at home or in another nonacute care setting—in the context of providing adequate, effective and humane care.

J. Scott Abercrombie Jr., M.D., is president of University Hospital at Boston University Medical Center. This opinion piece appeared in the Boston Globe on Tuesday, April 24, 1984.
Help For The Homebound

Home Medical, at age 109, helps lead national effort to improve care for the ‘at-risk’ elderly

A 82-year-old Roxbury man, normally confined by the painful limitations of arthritis and an ailing heart, is visited in his home by a physician and two fourth-year medical students. The physician sits down and chats with the man, who is partially deaf and lives alone in an efficiency apartment. The doctor asks a number of questions to verify that the man is taking his prescriptions properly, and to make sure he receives sufficient dosage levels.

The medical students set up a portable electrocardiogram machine near the bed, and ask the man whether his arthritis has been any more troublesome than usual. The physician helps the man to lie down on the bed so his heartbeat can be measured by the typewriter-sized ECG machine. Now lying down, the man answers that he has had more pain than usual when walking down the hallway outside his apartment. The physician offers to arrange for his patient to receive a special walking cane that provides more support than the one he is using.

After the ECG wires are disconnected and the remainder of the examination is completed, the physician orders a substitute prescription and promises to return the next week for a followup visit.

As a University Hospital Home Medical Service patient, the Roxbury man receives expert and personal medical care in the familiar surroundings of his home. If he were not a patient of the Home Medical Service, the man might be forced to make costly and inconvenient hospital visits, or be confined to bed at a hospital or nursing home.

Forming a national model

University Hospital’s Home Medical Service, which has provided primary medical care for the homebound of Boston for 109 years, has been awarded a grant from the Robert Wood Johnson Foundation of Princeton, N.J., to enlarge its services, to strengthen its ties with other home-care agencies and to collect data that will contribute to health-care policy making.

The Foundation grant, $141,715 for 1984 alone, is being used primarily to fund three projects, all intended to make HMS even more convenient for its patients, more cost-effective and a model for similar home-care programs nationwide:

- Home Medical Service is formally affiliating with the Boston Visiting Nurses Association (VNA), the Laboure Nursing Service and three local home-care corporations, which previously had augmented HMS medical care with nursing and social services. Under the new program, HMS, the VNA and the home-care corporations will coordinate more closely their efforts and develop a common system for assessing the quality and progress of their services.

- A computerized information system will be developed to allow HMS to organize and study the program-assessment data, and to keep closer track of the progress of its homebound patients.

- Home Medical will make two new services easily available to patients: short-term rehabilitative care at Jewish Memorial Hospital, which has close University Hospital ties; and respite care at Resthaven Nursing Home, which is managed by the Hospital. Both facilities are located in Boston’s Roxbury section.

A personalized approach to medical care is what makes Home Medical special to its nearly 900 patients, most of whom are homebound and who average about 80 years in age. Patients avoid frequent hospital trips, which might be made difficult by the nature of their illnesses or disabilities, and they can remain comfortable in the familiar surroundings of their homes.

The HMS personal touch includes not only attentive medical checkups and treatment, but also help for patients in caring for themselves.
The patients' advocate

"When someone makes a phone call to Home Medical Service, he or she has instant access to a very elaborate health-care system," according to HMS Associate Director Anna Bissonnette, M.S., R.N. "We are the patients' advocate. People can have a hard time finding their way through the maze of the highly technical health-care system. We have a personal interest in the well-being of individuals, and we see them through the process," she said.

Chronic illness and diseases of aging are HMS's primary medical concerns. While the medical staff frequently encounters hypertension, heart disease and conditions that hinder mobility, like arthritis, the staff also must contend with diabetes, alcoholism and malnutrition, as well as with such social problems as poor housing.

"Many of the people who are referred to us need both doctoring and help with their social problems," said Bissonnette. "We can respond to problems the same day, and that's what makes this program unique. We're not a mobile emergency room, but sometimes we feel as though we are."

The Home Medical team consists of 15 full-time staff members: internists with a special interest in geriatric medicine; nurses; social workers; and administrative staff, plus additional members who provide part-time help in such specialties as dentistry, surgery, podiatry and pharmacy. Because medical education has been a primary HMS concern throughout its history, fourth-year Boston University School of Medicine students, serving a required rotation with HMS (the School's only mandatory rotation), also play an active role in patient care.

In addition to the individual home visits, weekly clinics are held at a dozen elderly housing highrises in Boston by the medical students and HMS physicians, including Home Medical Service Director R. Knight Steel, M.D., a professor of medicine and chief of the Geriatrics Section of the Department of Medicine at the School of Medicine, and director of Boston University's Gerontology Center. In the past year, Home Medical Service physicians, medical students, nurses and social workers made approximately 7,000 visits to patients in homes and outreach clinics.

Founded in 1875, HMS is the oldest continuously operating home-care program in the United States. Originally it was based at the Massachusetts Homeopathic Hospital—the name by which University Hospital was known from its 1855 founding until 1929—as a service for all Bostonians in an era when medical care frequently was delivered in the home. The poor
and indigent came to rely upon the Medical District Service, as HMS was then called, for free health care.

The focus changes to elderly

By 1930, the Medical District Service had been renamed the Home Medical Service, and its focus had shifted to home care for area families. Seventy percent of HMS patients in that period were children. In the 1960s, many families started to receive care at Boston's federally funded neighborhood health centers, and as the area's homebound elderly, disabled and chronically ill population increased in the past decade, those patients became the new mission of Home Medical Service.

As the country's elderly population continues to grow, the number of home-care services is expected to rise sharply. The Robert Wood Johnson Foundation award recognizes that the expanded Home Medical Service can serve as a model for building similar home-health agencies across the country.

By instituting formal ties with the Boston VNA and the three local home-care corporations, duplication of efforts will be reduced, resulting in lowered costs and more efficient home care. This also will enable the development of a single assessment system for the home-care program's medical, nursing and social services that can be shared with home-health administrators and policymakers around the country. Program assessments help answer such questions as: How do costs vary among patients and neighborhoods? What are the best methods for delivering services in an urban setting? How satisfied are patients with the care they have been receiving?

Data from the program assessments will be stored and processed in a computer information system, the second major goal of the Foundation funding. The computerized assessment system will allow Home Medical Service staff members to maintain personal contact with their patients while remaining unencumbered by extra clerical work.

"What we want to do with the Robert Wood Johnson grant is to find some way of not 'throwing the baby out with the bathwater,'" said Bissonnette. "We don’t want to lose the personal touch."

Patients and caregivers both benefit when hospital stays are shortened, but some HMS patients may require temporary hospitalization. Referrals to chronic-care facilities usually are from acute-care hospitals. But, working with Jewish Memorial Hospital, which is affiliated with the School of Medicine, HMS plans

Grant allows HMS to manage broad range of services for elderly

The elderly in need of health care and other necessary services can be faced with a bewildering range of options. Under the Robert Wood Johnson Foundation grant, these services are being coordinated through Home Medical.

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[Diagram of services provided by HMS]
to arrange, when needed, for patients to move directly from home into a chronic-care hospital, bypassing a stay in an acute-care facility.

**Plans for respite care**

Through Resthaven Nursing Home, a 240-bed facility managed by University Hospital, Home Medical plans to offer a permanent respite-care service. Occasionally, families caring for homebound patients will need to travel, or, for some other reason, won’t be able to offer proper care for a short time. A patient in such a family’s charge would need a temporary place in which to live and receive care. In the past, Resthaven Nursing Home could offer such respite care, but only when a bed was available.

“In one instance, the primary caregiver for an elderly gentleman had to leave the country for a funeral. Resthaven admitted the gentleman for the week that was required, and then returned him back home,” recalled Bissonnette. “It’s that sort of capability that we’re looking for. We want to move people in and out with ease.”

The HMS staff members view their work not just as administering health care, but also as providing a true community service. “There are invisible walls around some hospitals,” said Bissonnette. “Home Medical Service provides a valuable community outreach, a two-way street with the community.”

That service is readily apparent in the weekly clinics held at area apartment communities for the elderly, where 35 percent of HMS patients live. Many individuals in those apartment highrises can move about the building, but would be unable to travel to a doctor’s office or hospital. Usually a physician, accompanied by one or more medical students, sees patients in a modest room set aside in each building by the Boston Housing Authority or State Street Development Corporation to serve as a doctor’s office. A social service coordinator assigned to each apartment community coordinates the appointments by telephone, so patients are spared long waits for an examination.

**A focus on education**

Education has been a central feature of Home Medical Service since its creation, providing valuable training not only for medical students, but also for nursing and pharmacy students and other health-care professionals. Fourth-year students from the School of Medicine, all of whom are required to serve a four-week rotation with HMS under the direction of attending physician preceptors, deliver most of the medical care received by HMS patients. By providing primary care in the home, the students must not only use their medical training, but also must exercise judgment and sensitivity in unfamiliar settings.

“The students get an opportunity to make their own decisions,” noted George Rosenthal, M.D., assistant director for education of HMS, a physician with the Hospital’s Section of Internal Medicine and an assistant professor of medicine at the School of Medicine. Home Medical Service Director Steel, Rosenthal and Allen C. Waltman, M.D., an assistant visiting physician at University Hospital and instructor in medicine at the School of Medicine, make up HMS’s full-time physician staff. School of Medicine Associate Dean John F. McCahan, M.D., an associate visiting physician at the Hospital and a part-time HMS staff member, also visits homebound patients.

At the start of their rotation, the medical students read an operational manual prepared by Waltman to familiarize themselves with the Home Medical Service. While working together frequently on home visits, BUSM fourth-year students Kathy Bennett and Holly Cowan found themselves functioning smoothly and professionally as a team. “The two of us really have learned to work well together,” observed Cowan after the third week of their rotation.

**New era for Home Medical**

Home-care administrators around the country will be observing Home Medical Service’s growth and successes made possible by the Robert Wood Johnson Foundation grant.

“This is a new era for Home Medical Service,” said associate director Bissonnette. “The focus of Home Medical Service has changed over the past 109 years. It now is a primary-care geriatric service, and the funding will help it to become an even better service, working in harmony with other agencies. “Medicare, Medicaid, other reimbursement agencies, health-care services and policymakers at all levels will be watching this program. It’s pretty apparent too that health-care education leaders will be keeping a eye on this program.”

Steve Stiles, a free-lance writer, until recently was a communications intern in the Medical Center’s Office of Informational Services.
All Through The Night

Although a hospital is an institution that never closes, it does have differing “personalities” by day, in the evening and at night. The cool and watchful professionalism that ensures the continuity of care and the provision of hospital services never changes throughout the three-shift cycle, but the feel and tempo of the house is dramatically different from shift to shift. The people who staff the hospital by night—from nurses to security officers, from lab technicians to control engineers—make up a team that works in relative obscurity. On this page is a small glimpse of the nightside—and a salute to all the UH people who carry on the Hospital’s caring mission all through the night.

Teaching is a 24-hour-a-day concern at an academic medical center. Barbara Damon, R.N., of F-2 North watches as Boston University School of Nursing student Melinda Boye checks the blood pressure of patient Edgar Jeffries.

Left, Ann Marie Fleming, R.N., of Evans-8 West stops in at the Coronary Care Unit to check with Zachary Spiegelman, M.D., about one of her patients.

Below, an ambulance arrives at the UH Emergency Room, where the staff is ready around the clock to handle any situation.
Physician prepares to carry out a test in the Cardiac Catheterization Laboratory.
How Goes The Battle Against Heart Disease?

A progress report from University Hospital

The scene: A procedure room on the eighth floor of the Evans Building of University Hospital at Boston University Medical Center. A patient is stretched out on a treatment table. A catheter—a long, hollow tube—has been put into an artery in the patient's groin, and carefully threaded from there to a point in one of the three arteries leading to his heart.

A flickering image on a video screen near the table tells the cardiologist that the catheter has reached its target: a point in the patient's artery where a fatty buildup has created a dangerous narrowing.

With the catheter on target, the physician presses a button. There is a faint hiss, and a tiny, elongated balloon at the end of the catheter suddenly inflates, slightly widening the narrowed arterial opening. The physician moves a dial, checks the screen, and again presses the button, further widening the artery. The process continues for about 20 minutes, with each repeat balloon inflation increasing the patient's vital blood pathway—thereby decreasing his risk of heart attack.

Between 1968 and 1980, the heart-disease mortality rate fell by 30 percent.

The technique used by this University Hospital physician to attack the blood-vessel buildup is called balloon angioplasty. And although, like any form of therapy, it has its limitations, balloon angioplasty is one of an array of remarkable new tools being used in the effort to overcome heart disease.

Such tools, according to Thomas J. Ryan, M.D., chief of the Hospital's Section of Cardiology and the president-elect of the American Heart Association, are likely in the coming decades to have a major impact in the struggle against the nation's number-one killer. Other such tools include:

- A new generation of drugs, called thrombolytic agents, for the treatment of heart-attack victims. Ryan, a professor of medicine at Boston University School of Medicine, said one of the most promising of these drugs is called a tissue-plasminogen activator. “This drug doesn’t affect clotting elsewhere in the body,” said the physician, “but when it encounters a clot in the blood vessels, it activates internal enzymes in the clot and the clot disappears.”

Tests of the agent are to begin at University Hospital and a number of other teaching hospitals around the country in the near future. If the drug proves to be as effective in humans as it is in animal studies, said Ryan, “we will, for the first time, have a means of reducing the amount of damage done by heart attack.”

- New techniques for boosting the success rate and the flexibility of balloon angioplasty. Included are new drugs that cut the rate at which blood-vessel buildups recur, and refinements that will permit widespread use of lasers to attack buildups that do not lend themselves to balloon angioplasty. (For reports on research into both these possibilities, see page 13.)
New methods for identifying people who are especially prone to heart attacks. One technique, developed by researchers at University Hospital, utilizes the traditional "treadmill" stress test to gauge whether a heart patient is at serious risk of suffering a second attack—a technique that then permits doctors to take protective measures.

Steps forward in surgery

Along with these various nonsurgical advances have come some major steps forward in the surgical realm. For example, advances in the coronary bypass operation—in which a vein or an artificial blood vessel is used to replace atherosclerotic arteries near the heart—have made this once risky procedure all but routine. “The anticipated mortality in these operations is about 2 percent, which means that the vast majority of bypass patients survive the operation,” said John R. McCormick, M.D., of UH’s Department of Cardiothoracic Surgery.

The bypass, though, traditionally has been reserved for patients who were in relatively good shape—for example, the patient with a serious but not life-threatening case of the painful ailment known as angina pectoris, which is often a precursor of heart attacks. The operation was thought to be too risky to be used with more seriously ill patients.

However, experience with a group of recent heart attack victims at University Hospital suggests that the bypass also can work for these patients.

“We have had several patients who had suffered recent myocardial infarctions (heart attacks) and were having continuing angina pain. They were going to die if nothing was done. We went ahead and did bypass operations on them,” reported McCormick, “and they have survived; most of them have done quite well.”

(For one such patient’s experience, see page 18.)

The prospect of future progress in treating heart disease comes against a backdrop of impressive gains achieved in recent years.

Marked decline in mortality

“Over the past two decades, we have seen a marked decline in mortality due to heart disease. Since the late 1970s, that decline has reached about 30 percent,” said Ryan. That means heart disease today is claiming roughly 200,000 fewer lives a year than it did 15 years ago.

Such progress, of course, must be measured against the stark reality that heart disease is still a menace. The disease claims roughly 700,000 lives each year, nearly twice the toll taken by cancer. It is, moreover, a disease in which the medical community, while accumulating effective new tools for preventing death from heart attacks, increasingly faces constraints imposed by the clock: Roughly half the Americans who annually fall victim to heart disease die suddenly, giving doctors no chance to apply their new techniques.

Nevertheless, there has been much progress. And although there are no definitive answers on exactly what accounts for the drop in heart-related deaths, it is clear that credit must go both to medical advances and to the public’s heightened interest in preventive measures, such as quitting smoking or watching one’s blood pressure.

In terms of medical advances, said Ryan, one key factor has been the growing sophistication of treatment. A well-equipped and well-staffed coronary care unit, such as UH’s, can keep a very close watch on a patient’s condition, and at the first sign of trouble—often an irregular heartbeat—can step in. “We know that the prompt treatment of an irregular heartbeat can save the life of a patient who otherwise would die,” Ryan explained.

Also helping to cut the death rate are the many additions to the storehouse of therapies available for treating the patient with heart disease. Some of the drugs, said Ryan, were initially developed for other
Coronary disease was occurring in epidemic proportions

New weapon against hypertension

One good example, said Ryan, is the drug captopril, which received much of its early development here at Boston University Medical Center for its use as a treatment for hypertension. Since the drug first became widely used about three years ago, it has lived up to its early promise of being one of the most valued weapons against hypertension. (For more on BUMC's role in the struggle against hypertension, see page 15.)

However, captopril also has proven very useful in treating heart failure. "For people with badly damaged heart muscles, we used to reach the point where there was nothing more we could do," said the cardiologist. "Now, we add captopril to their treatment regimens, and we are finding that these patients can do very well over a substantially long period of time."

While improved treatments are one reason why heart disease death rates have been dropping, they clearly are not the only reason. A large part of the drop also reflects prevention: stopping heart attacks and heart failure before they occur. And here again, University Hospital and Boston University School of Medicine have played prominent roles.

In the late 1940s, researchers wondered if they could gain insight into the causes of heart disease by monitoring the health patterns and lifestyles of some 5,000 Framingham, Mass., residents over a period of several years. It was the first time that the principles of epidemiology had been applied to a chronic disease: Previously epidemiologists had concentrated on acute ailments like pneumonia and typhoid fever. The Framingham project, therefore, wasn't given much chance for success.

"To many epidemiologists, it didn't seem appropriate to do epidemiological studies of a disease like coronary disease, even though it was pointed out that coronary disease was occurring in epidemic proportions," said William B. Kannel, M.D., chief of UH's Section on Preventive Medicine and Epidemiology.

The team involved in the Framingham project persisted, however, and the result of the effort was the now world-renowned Boston University-Framingham Heart Study, which for the first time spotlighted many of the risk factors that make people prone to heart attacks. (Indeed, the very term "risk factor," which today is employed in describing all manner of health conditions, first appeared in a paper published by the Boston University-Framingham group.) The major risk factors for heart disease, as postulated by the Framingham Study and reiterated by numerous subsequent studies, are smoking, high blood pressure and high cholesterol levels in the blood.

Study promotes healthier lifestyles

Those findings, combined with similar results from other studies, helped trigger a national push for healthier lifestyles. Perhaps most impressive has been the progress against smoking. An estimated 25 million Americans have quit smoking over the past 10 years, and only about one-third of middle-aged men—the highest-risk group for heart attacks—still are hooked on tobacco.

Besides identifying factors that underlie heart attacks, the Framingham Study also has led to major discoveries about previously unknown aspects of heart disease. For example, said Kannel, a professor at...
BUSM and the former director of the Framingham Study, one finding involves a phenomenon known as the “silent” heart attack. “The Study has revealed that from one-quarter to one-third of all heart attacks are silent,” said the physician. “In half of these, the patients could remember nothing in the way of symptoms that even remotely resembled a heart attack. Other patients remembered complaining of some possibly atypical symptoms that neither they nor their physicians considered signs of a heart attack.”

The knowledge of this problem has spurred researchers to seek new ways to reduce the risks facing heart-attack victims. For example, said Kannel, research has emphasized the need to test certain high-risk groups—for example, middle-aged men who are hypertensive, hypercholesterolemic, overweight and who smoke—to see if they suffer from silent heart disease. Testing is of necessity a complicated and sometimes confusing procedure, he noted. Yet in light of the widespread nature of the silent attacks, he and other researchers believe tests make sense for such people.

What about long-term prospects in the struggle to reduce the toll of heart disease?

Cardiology chief Ryan emphasizes there still is much to be learned about what causes heart disease, and also what can be done to treat it.

“We don’t know, for example, about the role of viral illnesses in heart disease,” he said. “There is some research that shows such illnesses cause damage to blood vessels in animals. So there’s a subject to which we’ll all have to pay more attention.

“At the same time, we need to examine new ways of reducing atherosclerotic buildup in the blood vessels. I think that in time, we are going to see such advances as the formulation of chemical agents that can dissolve cholesterol buildup in the arteries.”

Such advances, Ryan hastened to add, would not mean the elimination of heart disease as a major cause of death. “All the blood vessels in the body are made in such a way that it’s a natural process for them to harden up eventually.”

But if there is no realistic prospect of wiping out heart disease, as has been done with smallpox, the possibilities for further gains are still great, said Ryan. “The therapies and preventive measures available 15 years from now, at the end of this century,” he added, “may amaze us all.”

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Diane Ganem, R.N., chats with Coronary Care Unit patient Joseph Falcone.

Richard P. Anthony is a free-lance writer who lives in Boston.
An Array Of Remarkable New Tools And Techniques

In heart disease, as in other areas of medicine, it is the dramatic new therapies that usually draw the headlines. Yet most major advances come only after a long and often frustrating process of experimentation and research.

Virtually all the physicians who are staff members of University Hospital are involved in one form or another of research. Some of it is what is known as clinical research—that is, studies directly related to devising new types of therapy, or improving existing types. Other research is aimed at gaining basic knowledge, which lays the groundwork for the next generation of gains in heart-disease treatment.

The following are a few examples drawn from the highly diverse research program in heart disease now under way at University Hospital and Boston University School of Medicine:

New directions in angioplasty

Balloon angioplasty—the technique of widening blood vessels through the use of special balloons mounted on catheters—has proven highly effective against certain types of buildups in the arteries. But it is somewhat limited, said David P. Faxon, M.D., director of UH's Cardiac Catheterization Laboratory. For example:

- Some blood-vessel buildups cannot be treated because they occupy too much of the artery, leaving too little room for the catheter to go through.
- In roughly a third of the patients treated with balloon angioplasty, the buildups return within six months to a year.

Faxon, who also is an associate professor of medicine at Boston University School of Medicine, now is involved in a multipronged effort to find solutions to both problems.

The return of buildups in arteries is a process called restenosis, said Faxon, and medical scientists think they know what causes it. When the balloon is inflated, and drives the buildup of fatty material back against the blood vessel walls, the walls tear. As a result, blood clots form.

"Among the major components of clots are platelets—tiny elements in the blood that have the property of getting 'sticky,'" said Faxon. "The platelets then serve as the nidus, or focus, for the start of a new atherosclerotic buildup."

Faxon and his co-investigators believe that if they can make the platelets less sticky, it may help to prevent the buildups, or plaques, from reappearing. "We've looked specifically at drugs that prevent platelets from sticking to the vessel walls, and we've shown, in animal experiments, that we can prevent restenosis by using these agents," he explained.

"Now, we're looking at a newer, even more potent drug for preventing restenosis. It's called thromboxane synthetase inhibitor, and if it proves effective, we may then be ready to seek permission to use this drug in human patients."

New set of drugs introduced to help in struggle against angina

At the same time Faxon and his associate, Timothy A. Sanborn, M.D., a staff physician at University Hospital and an assistant professor in medicine at the School of Medicine, are trying to improve the outlook for balloon angioplasty patients, they also are examining an entirely new form of angioplasty—one that uses the laser instead of the balloon-like device.

The laser has been tried as a technique for removing atherosclerotic plaques in just a few patients treated at other medical centers, noted Faxon. Yet many problems must be overcome before lasers can be widely used in such treatments. Finding a precise way to direct the laser beam within the blood vessels is one problem. Without such a technique, the laser may harm healthy blood-vessel tissue. Another problem is identifying the right type of laser, since laser beams from different sources have different impacts on plaques.

Again using experimental animals, the UH researchers have tested different types of lasers. Their work so far has given them hope that one type of laser—the kind generated through argon gas—may prove a good alternative for treating clots, if not the actual plaques.

Meanwhile, the researchers are hoping that another new technology may help them solve the problem of
Cardiac catheterization is a key tool in diagnosing and treating heart disease.

directing the laser beam. The technology is that of fiber optics. It involves transmitting light signals through tiny glass “wires.” Mounting these fibers on a catheter, noted Faxon, may give cardiologists a TV image of the buildup they are planning to attack with the laser.

This technique, he added, already has been tried, but only in very large arteries. Faxon and his associates currently are investigating whether much smaller optical fibers—fibers small enough to fit inside a coronary artery the size of a pencil point—can be successfully used in laser angioplasty.

Weapons in the struggle against angina

Angina is often the first warning sign of a potentially dangerous narrowing of the arteries. It usually is caused by a dropoff in the flow of blood to the heart, and often is first experienced during exercise—a time when the heart’s demand for blood is at a peak. Angina’s main symptom is a wrenching pain that is sometimes so devastating it leaves its victims unable to work or to otherwise lead normal lives.

There traditionally have been two basic therapies for angina, according to Donald Weiner, M.D., head of UH’s Non-Invasive Cardiology Laboratory and an associate professor of medicine at BUSM. One method involves the use of a group of drugs called nitrates. These medications expand the blood vessels leading from the heart, and thus make it easier for the heart to pump.

The other approach involves a group of medications known as beta blockers. They prevent the heart from getting signals that would make it beat faster. “When you’re frightened or angry,” explained Weiner, “your heart rate starts to increase. That’s because hormones are pouring out of your adrenal glands, and when they get attached to your heart, they cause it to beat faster. The beta blockers work by stopping the hormones from attaching to the heart muscle.”

Though both beta blockers and nitrates remain valuable weapons against angina, they have their limitations. Nitrates, for example, are not powerful enough to control the pain from severe angina. Beta blockers cause a variety of side effects. Moreover, because they have effects all over the body, they cannot be taken by certain angina victims—those who also have lung disease, for example.

Calcium channel blockers introduced

Now, though, medical science has introduced a new set of drugs into the struggle against angina. They are called calcium channel blockers, and, according to Weiner, they combine some of the best features of both nitrates and beta blockers.

“The calcium channel blockers dilate blood vessels,” explained Weiner. “They are similar in that respect to the nitrates, but they’re more powerful. These new agents also tend to decrease blood pressure. That’s similar to the beta blockers, but different from the nitrates.”

It might seem that calcium channel blocking agents, some of which were first developed or tested at University Hospital, are an ideal treatment for angina. But such drugs now on the market, said Weiner, still
have liabilities. They must be taken as often as six times a day, which makes it very difficult for some patients to stay on their medication. And they are extremely expensive—up to three times as costly as beta blockers.

“We're now experimenting with a type of channel blocker that is longer-acting, and which may only have to be taken once or twice a day,” said the cardiologist. “I think that's going to be an important advance in calcium-blocking therapy. When a patient takes a medication less often, his compliance rate is much better. In addition, it appears that this agent could be a good deal cheaper than the ones now on the market.”

What happens to fats in the bloodstream?

Some 30 heart patients undergoing routine cardiac catheterization at University Hospital recently volunteered for an unusual task: They agreed to drink milkshakes that contained, besides the normal ingredients, several ounces of safflower oil.

This was not because safflower oil adds flavor to the standard milkshake, said Alice Jacobs, M.D., a staff physician in UH’s Section of Cardiology and an assistant professor of medicine at BUSM. In fact, she said, a little apologetically, the milkshakes really did not taste very good.

But what the patients were helping Jacobs and her associates to do was to gain basic insights into what happens to fats taken in by the body. The safflower oil, because of its very high fat content, was thus an important ingredient in the experiment.

After the patients had consumed the milkshakes, said Jacobs, and during the catheterization procedure, blood samples were taken from various points within the cardiovascular system—for example, from arteries and veins entering and leaving the liver and lung.

“What we found, to our surprise,” said Jacobs, “is that the liver plays a major role in metabolizing a blood substance called chylomicrons.”

Chylomicrons are important because they ferry another type of substance called triglycerides through the bloodstream. Triglycerides, in turn, are a major fat component in the blood—with the other such component being the much better known substance, cholesterol. While the role of triglycerides in heart disease is not as well understood as that of cholesterol, Jacobs noted, there seems little doubt that triglycerides are involved in some way in the fatty buildups on the artery walls.

The reason the finding was a surprise, said Jacobs, is that medical scientists up to now had thought that all chylomicrons come through the body's lymphatic system.

What does the discovery mean? Jacobs was quick to note that its value in terms of specific strategies for preventing or treating heart disease is not yet clear.

“It is a step in unraveling how the body metabolizes lipids (fats),” she said, “which may in turn provide insight into how fats are accumulated in arteries.”

In effect, the discovery is one piece of a mosaic that, when more complete, will give medical science a much clearer idea of how the body deals with the fat taken in as part of the diet. That knowledge then may help to pave the way for new strategies in the treatment and prevention of coronary heart disease. □ RPA

Hypertension: a menacing and silent disease, but one that is treatable

Hypertension (high blood pressure) is a “silent” but potentially very dangerous disease.

Except in extreme cases, it has no visible symptoms. Many people are unaware that they suffer from it. Yet hypertension has been scientifically linked to the buildup of atherosclerotic plaques in the arteries, which in turn are the chief cause of heart attacks. In addition, serious hypertension can, by itself, produce an often fatal form of heart failure.

Yet while a menacing disease, hypertension also is the most treatable of all chronic ailments, said Aram V. Chobanian, M.D., chief of the Section of Hypertension at University Hospital.

“Thirty years ago, relatively few hypertensives could control their blood pressure,” said Chobanian, who also is a professor at Boston University School of Medicine and director of Boston University’s Cardiovascular Institute. “Now we’ve reached the point where practically everyone can attain some degree of control and where most people can have their blood pressures brought down to the normal range.”

(The normal range is considered to be a systolic pressure—pressure during a heart beat—of from 100 to 140, and a diastolic, or between-beat pressure, of from 70 to 90. A reading between 140/90 and 160/95 is considered mild hypertension, and anything above that is considered moderate to severe.)

Remarkable progress in treatment

There has been remarkable progress in the treatment of hypertension. And much of it is due to advances made over four decades by researchers at Uni-
The first major step, which took place in the 1940s, was the development of an operation for treating hypertension by Reginald Smithwick, M.D., who later became UH’s surgeon-in-chief.

Not long after Smithwick’s innovation, however, came a series of new drugs that would eventually minimize the need for surgery. The first of these, which BUMC developed in the ’50s, made use of a medicinal plant used in India as a means of reducing anxiety. Robert Wilkins, M.D., UH’s physician-in-chief, showed that an extract of this plant could be used in the regular treatment of high blood pressure.

The drug that resulted, called reserpine, gave doctors their first important medicinal weapon against hypertension. It was one of the landmark achievements that would eventually bring to Wilkins the Albert Lasker Award of the American Public Health Association and the Gold Heart Award of the American Heart Association. Wilkins, like Ryan, became president of the AHA.

The development of reserpine was followed in the later ’50s and early ’60s by the development of a group of drugs called diuretics, which help the body rid itself of water and salt. These drugs—which Chobanian helped to develop during his early years at University Hospital and Boston University School of Medicine—remain in wide use. The diuretics, however, were but one in a continuing succession of new drugs to emerge from the laboratories and clinics of Boston University Medical Center.

One of the most important of the more recent new agents is captopril. “It’s a drug that was developed on the basis of some earlier work done here, in which it was shown that a certain enzyme regulates the production of a substance called angiotensin, which causes blood vessels to constrict,” said Chobanian. “On the basis of work performed by Haralambos P. Gavras, M.D., a BUSM professor of medicine and head of the Hypertension Section at Boston City Hospital, it was felt that if you could block this enzyme, it would be a very effective way of lowering blood pressure in a lot of people.”

After development of an agent that could block the action of the enzyme, animal studies—and later clinical trials performed here—proved the theory right. As a result, captopril now is one of key drugs used by the medical profession in the control of hypertension.

The many new forms of treatment for hypertension that have been developed at Boston University Medical Center have gained it an international reputation in the field. In 1975, BUMC was named a National Center of Research in Hypertension and Atherosclerosis. It is one of only four medical centers in the country chosen to fulfill that role by the National Heart, Lung and Blood Institute.

The introduction of ‘step-care’

Besides producing a remarkable array of treatments, Boston University Medical Center also was the source of the current conventional approach to treating hypertension. It is called “step-care,” and it basically involves using a series of different agents to fine-tune the control of hypertension.

“The body has a way of readjusting itself if you just use one agent,” explained Chobanian. “In other words, if you are taking a diuretic, the body eventually tries to retain sodium again. When this occurs with step-care, you add another drug with a different type of action to offset the body’s compensation. In effect, you use a series of agents so as stay ahead of the body’s own control mechanisms.” □ RPA
White-water kayak flip gave him a bit of a scare—but his heart held up fine

PATIENT LAWRENCE RYAN

LAWRENCE Ryan remembers the episode vividly.

It was last summer, and he was on his first kayak expedition, paddling down Maine's Kennebec River. The boats had reached an especially turbulent stretch of the river when Ryan's kayak suddenly went over. He was swept downstream, still in the boat, his body submerged and hanging upside down over the rocky riverbed.

At length, he managed to wriggle free. "I came up for a breath of fresh air, and a big wave hit me in the face," he recalled. "I filled up full of water, and I was coughing and spitting, and I said to myself, 'I'm going to die.' It was really scary."

At that point, the expedition leader plunged into the water and helped Ryan get to shore. "I just stood up on the bank and I said to myself, 'If I didn't have a coronary just now, I'm never going to have a coronary."

Ryan, a businessman from Bridgewater, Mass., did not have a coronary—a short-hand term for a heart attack. But he had plenty of reason to be worried about it. His father died of a heart attack, and his brother and sister have both had heart trouble. Moreover, Ryan himself had once been a victim of angina—a wrenching pain usually caused by atherosclerotic buildups in the arteries that prevent enough blood from reaching the heart. Roughly three years before the kayaking expedition, in fact, Ryan's angina had gotten so bad that, even though he was on various medications, he could only exercise a few minutes at a time.

'T'd...keep on walking'

"My idea was to try to stay in as good a physical condition as I could under the circumstances, so I used to go out on walks," he remembered. "I'd walk as far as I could and then I'd sit down on the curb, sometimes for as long as a half-hour at a time. Then I'd take a couple of nitros (nitroglycerin tablets, a standard therapy for angina) and I'd get up and keep on walking."

Eventually tiring of the pain, as well as of the side effects of the drugs, Ryan started looking for another way to deal with his angina. His local doctor referred him to David P. Faxon, M.D., chief of UH's Cardiac Catheterization Laboratory.

Preliminary tests showed that Ryan did indeed have a very severe atherosclerotic buildup. But it only was in one of the three coronary arteries, which are the vessels that carry blood from the lungs to the heart. That fact, combined with Ryan's age—he was 36 at the time—and his good physical condition, meant that he qualified for the then still experimental treatment called balloon angioplasty. In this form of treatment, narrowings in arteries are widened by a specially designed balloon that is mounted on a catheter. (See the story starting on page 13 for more on the nature of balloon angioplasty.)

Ryan knew that the treatment was not guaranteed to succeed. "Dr. Faxon told me that 25 to 30 percent of the people who had the treatment would have a recurrence within six months to a year," said Ryan. He also knew there was a slight but definite possibility that his artery would burst, in which case he would have an immediate bypass operation. But he considered the risks worth taking, and agreed to the procedure.

'You try to be macho...'

"There was one thing that I really remember," said Ryan. "When I was in that procedure room, I was scared. You try to be macho—'Yeah, I can handle it,
no problem'—but inside, I was scared. And there was a woman in the room—I think she must have been a nurse—and she walked up to me, grabbed my hand, and held onto it through the whole thing. That was a really nice experience, because I really wanted somebody to tell me that everything was going to be all right.”

As it turned out, everything was all right, and has remained so. In the nearly four years since the angioplasty procedure, Ryan has not been bothered by angina, even though he exercises much more vigorously—witness the white-water kayaking incident—than he was able to before the treatment.

That fact, said Ryan's doctor, is pretty strong evidence that the artery affected has not suffered restenosis—the technical term for a return of arterial build-ups. “If important restenosis occurs,” explained Faxon, “you'll have angina again.”

Ryan himself, while not ruling out the possibility of future heart trouble, is delighted to have his health back. A former karate instructor, he puts emphasis on staying in top physical condition. “I run all the time and play racquetball, and I've started to try white-water kayaking. To me, that's a lot of what life's all about.”

His renewed ability to lead the type of active life he treasures, said Ryan, is something for which University Hospital gets a major share of the credit. “I can't say enough about the people at the Hospital, and what they did for me.” □ RPA

An unusual bypass operation gave this survivor what he calls a 'second gift of life'

PATIENT LOUIS LOWY

It started with some mild chest pains, recalled Louis Lowy, Ph.D.

“I had just returned from vacation, and I was in my office,” said Lowy, who is associate dean of Boston University's School of Social Work and a world-renowned gerontologist. “It was the very first time in my life I had experienced any chest pain.”

Lowy, 63, did not think the pain was worth worrying about, but Mary Jane Bricout, director of financial services at the School, did: She rushed him to University Hospital.

“I went to the emergency room,” said Lowy, “and there I really started to experience some terrible pain.” He therefore was not surprised when the UH doctors treating him came in with their diagnosis: heart attack.

The attack, said Lowy, was a moderate one. His physicians put him on a drug regimen, which is the standard way of treating such heart attacks, and said that if all went well, Lowy would be able to resume a normal schedule within four to five weeks.

As sometimes happens with heart trouble, though, all did not go well. Two weeks after the first heart attack, which occurred in mid-August of last year, Lowy suffered a second, much more serious, attack.

At this point, said Lowy, his physicians wanted to get more information about the severity of his condition. They began to carry out an angiogram—a procedure in which dyes are injected into the arteries so that the condition of the vessels can be better examined by means of x-rays.

“It was very clear that the arteries were clogged,” said Lowy. “They did not complete the angiogram, because in my condition, it was too risky.”
Intra-aortic balloon inserted

To help improve Lowy's blood circulation, a device called an intra-aortic balloon was placed in his aorta—the large artery that carries blood from the heart to the lower regions of the body. Even with that assist, though, the patient's chances seemed poor, recalled John R. McCormick, M.D., of UH's Department of Cardiothoracic Surgery.

"He was requiring more and more medication to keep his circulation up," said McCormick, a BUSM assistant professor of surgery. "It looked as though he was probably going to die."

By this time, Lowy's physicians had exhausted most of the standard treatments for heart-attack victims. There was one other possible approach: a coronary bypass operation. The operation would permit the surgeons to bypass the narrowed arteries that were causing Lowy's drop in circulation. But the problem was that bypass operations traditionally have been considered very risky in treating recent heart-attack victims.

"In the past, we've been very hesitant about carrying out a coronary bypass graft in patients who have had a recent myocardial infarction," said McCormick. "The risk of mortality under such circumstances has been thought to be unacceptably high."

University Hospital surgeons, however, had had recent success in using the bypass for heart attack victims. So even though Lowy's condition was worse than that of the patients treated earlier, the decision was made to do a bypass on him.

Lowy, heavily sedated during much of this time, was not deeply involved in the discussions leading up to the operation. He was aware, though, that the chances for success were limited.

Family involved in decision

"Members of my family were very much involved in the decision," he said, "and what I really treasure is the way in which Dr. McCormick and Dr. Paul Levine (a UH cardiologist and a BUSM assistant professor of medicine) involved them—not just telling them what the situation was, but preparing them in a frank but humane way for the possibility that I might not make it."

The three days following the operation were the key ones. Lowy, hooked up to various life-support systems, could not talk during this period. But he was able to listen, and to communicate by writing notes.

"Someone asked me, 'What is your sense of how you are doing?' and I wrote down, 'Very apprehensive but confident.' I do not think that was just to reassure my family. I think those words reflected my true feelings. I was very apprehensive and I knew that I might not survive. I made my peace, as one makes one's peace at these times.

"But I also had the sense that I might make it. In fact, I said to my family, after I could speak again, 'You know, I still have things to do.' I didn't mean just enjoying myself, but things to do professionally."

A 'professional survivor'

As it happens, Lowy had had an earlier, although very different, experience of surviving under difficult circumstances. He spent four years as a prisoner of the Nazis during World War II. For half of that period he was incarcerated in the notorious death camp at Auschwitz.

Although his colleagues now jokingly refer to him as a "professional survivor," Lowy said he thought very little about his Auschwitz experience while being treated for his heart attacks. "The only thought I had about it was that I had survived once, and I want to survive again." In retrospect, though, he said that will to live could have been an important factor in helping him survive his heart problems, as it was in helping him to survive Auschwitz.

Today, Lowy is grateful about what he describes as his second gift of life, and grateful for the role University Hospital played in his recovery.

"My family and I agreed that it was the best possible institution for me," said Lowy. Moreover, he is convinced that other patients were treated with equal humanity and concern. "I saw no evidence that I was getting preferential treatment because I am from Boston University. I was able to observe the way the doctors and nurses dealt with my fellow patients, and it seemed to me there was a real sense of caring."

For Lowy, now largely recovered from his operation, a new challenge has arisen: deciding how far he should try to go in resuming his pre-attack work schedule. It is a nettlesome issue, he confessed, because he enjoys his work, but he also knows it is unrealistic to think he can be as active as he was before his illness. On the other hand, Lowy quickly noted that it is much preferable to face this kind of dilemma than to have to be worried about survival.

"I have to decide, now that I have this new gift of life, how I should make the best of it—for myself, for my family, and for my colleagues. It is a problem, but I think it is less of a one for me than for some others. Some people, you know, say things like, 'Why did it have to happen to me?' I never said such things or had such thoughts." □ RPA
Getting Back Into The Swing Of Things

Where once a heart attack meant the end of work, exercise and the everyday rhythm of life for most victims, it is increasingly common today for victims to resume many pre-attack activities within a few months—and sometimes even a few weeks—after they have been afflicted.

Still, medical professionals who care for heart patients are keenly aware that the return to normal activities is seldom smooth or trouble-free. Heart patients, especially if they have had long or complex treatments, often are depressed and worried. They and their families may have been told beforehand that the chances for a return to a normal lifestyle are good. But the reality during the recovery period may look very different to both patient and family.

While much of the task of getting a patient back into the normal swing of life is left to the patient’s family, and to his or her family doctor, University Hospital is increasingly seeing this support as part of its overall responsibility, too.

Nurse-consultant Cheryl Phillips briefs patient Angelo Fusaro and his wife, Hilda, and son, William, on his surgery.

Cheryl Phillips, R.N., a nurse-consultant at the Hospital, has originated a unique patient and family support program within University Hospital’s Section on Cardiothoracic Surgery.

Her basic role, Phillips explained, is to make clear to both the patient and family members how the operation is likely to affect them, and to help them deal with its impact. This means getting the family members together before the operation, and being available afterwards to answer questions or simply to listen to worries.

“Most of the patients are men, and for many of them, this is the first time they haven’t been able to be in charge,” she said. “It’s frightening for them, and it’s frightening for their families. But we find if we can talk about the recovery period, and about their getting back to work, it reduces a lot of this concern.”

Some patients, she added, seem to respond very quickly to the assurances and the counseling that she provides. Others take a longer time to return to achieve emotional stability. But however long the process takes, Phillips remains available to help whenever the anxiety level starts to rise.

Coronary artery bypass surgery and the power of positive thinking

“The power of positive thinking” to many people is just a catch phrase, but in the case of coronary artery bypass patients it apparently plays a real role in predicting not only patient recovery, but also whether the patient will return to work. A study conducted by Boston University School of Medicine researchers at University Hospital and three other medical centers around the country concluded that whether or not a heart-surgery patient returns to work after recovery is largely determined by his or her attitude prior to the bypass operation.

The BUSM-UH researchers studied 318 coronary artery bypass graft surgery patients as part of an ongoing study of the course of recovery and rehabilitation after major cardiac surgery in a cohort of 539 patients. They examined the patients’ physical outcomes, psychoneurological function, role functions in the workplace and at home, economic changes, family and marital relationships, psychological states and general recovery issues.

The researchers found that the factors responsible for the patients’ successful recovery were psychological and socio-economic rather than medical, and were present prior to surgery.

According to the study, one of the strongest predictors of postoperative employment status was the patient’s answer to the following question: “Do you feel that you will be able to go back to work after your surgery?” Of the patients who expected before their surgery that they would return to work, 82 percent did return, compared to a 39-percent rate for patients who prior to surgery were either uncertain or who did not expect to return.

Principal investigators for the study were Babette-Ann Stanton, Ph.D., of the Department of Behavioral Epidemiology at Boston University School of Medicine, and C. David Jenkins, Ph.D., former chairman of that Department and now with the University of Texas Medical Branch, Galveston. Other study researchers were Michael Klein, M.D., of University Hospital’s Department of Cardiology and an associate professor of medicine at the School of Medicine, and Judith A. Savageau, M.P.H., Roberta Aucoin, R.N., and Philip Denlinger, all of the BUSM Department of Behavioral Epidemiology.
University Hospital's Thomas J. Ryan, M.D., who this year became president-elect of the American Heart Association, decided when he was a medical student in the early 1950s that he wanted to specialize in cardiology.

It is a decision he has never regretted, said Ryan, now head of University Hospital's Section of Cardiology. And while he has found many aspects of cardiology rewarding, perhaps the most fulfilling part has been helping heart patients to survive, and in many instances to return to their normal ways of life.

'It's tremendously rewarding'

"Heart patients tend to be younger patients, in the prime of their lives," he noted. "When I first entered the field of cardiology, rheumatic heart disease was a terrible problem, which often affected mothers with young children. Today, the typical patient is a middle-aged man, who as likely as not is at the peak of his career. In either case, it's tremendously rewarding when you're able to help one of these patients."

Ryan's career has been heavily oriented toward patient care, but he also has found time to make major contributions in the areas of clinical research and the

(Continued on Page 22)

Although Arthur J. Roberts, M.D., wanted to be a heart surgeon from the time he was a boy growing up in Holyoke, Mass., he also had another interest—football. And while many youngsters share that interest, not many pursue it as successfully as Roberts, who was an outstanding college player and then—during his medical training—was a quarterback for the Cleveland Browns and for the Miami Dolphins.

Roberts, who recently was appointed chief of UH's Department of Cardiothoracic Surgery and professor and chairman of the School of Medicine's Department of Cardiothoracic Surgery, was a star quarterback in his college years at Columbia University. While studying at Case Western Reserve University School of Medicine, which is located in Cleveland, Ohio, he was able for a time to pursue both his medical training and his pro-football career.

"The Browns' practice field at that time was located on the Case Western Reserve campus," said Roberts. "During the football season I was able to go to classes during the morning and work out with the Browns in the early afternoon."

When he was traded to the Dolphins in 1967, after two years with the Browns, Roberts found he could

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training of young cardiologists.

A native of Long Island, N.Y., Ryan attended Holy Cross College in Worcester, Mass., and Georgetown University Medical School. Prior to joining University Hospital in 1971, Ryan was chief of cardiology at St. Elizabeth's Hospital in Boston's Brighton section.

Over the course of his career, the cardiologist has conducted a variety of research projects. He has had a longstanding interest in coronary angiography and solving the the problem of sustaining blood flow so as to avoid damage to the heart. More recently, Ryan has headed University Hospital's participation in a number of national clinical studies sponsored by the National Heart, Lung and Blood Institute. Included is a systematic look at how much coronary bypass surgery does to prolong the lives of angina victims and survivors of heart attacks, the main focus of the highly regarded Coronary Artery Surgery Study, of which Ryan is a principal investigator. He also is a principal investigator of the new National Heart, Lung and Blood study of clot-dissolving drugs that are to be used in the early stages of heart attacks (thrombolyis in myocardial infarction, or TIMI).

Ryan also has been active in a variety of professional organizations, especially the American Heart Association, which he will head next year. He is a former president of the Massachusetts affiliate of the AHA. He has served as governor of the American College of Cardiology and is a member of the Association of University Cardiologists.

Although the cardiologist has witnessed a great many advances against heart disease over the course of his nearly 25 years in the field, he also believes that there is a tremendous amount left to do.

'Many problems left to be solved'

"There's still an awfully large number of people who are dying of heart disease every year," said Ryan, "and there are a great many problems yet to be solved. The challenge for cardiologists is to pick the problems that we think best lend themselves to solution, given the limited resources at our command."

Ryan and his wife, Nancy, live in Newton, Mass. They have six children. □

Heart Surgeon Roberts

(Continued from Page 21)

no longer continue both his medical training and his football career, since his clinical clerkship was beginning. So after one fall season with the Dolphins, he resumed his studies at Case Western Reserve and graduated with his original medical school class.

Following his graduation from Case, Roberts spent two years as an intern and resident at Yale-New Haven Hospital, and subsequently continued his training as a clinical associate in cardiac surgery at the National Heart and Lung Institute in Washington, D.C.

After two years in Washington, Roberts entered the Cornell-New York Hospital Medical Center in New York City, and completed residency in general surgery and cardiothoracic surgery. He took his first attending physician position at Northwestern University in Chicago. In 1981, he joined the Department of Surgery at the University of Florida Medical Center in Gainesville.

Roberts said being a heart surgeon means, among other things, being subject to wide swings of emotion, depending on the outcome of surgery. It is a way of life, he added, that he has been trained to handle. "To treat a patient with serious heart disease, and to take the patient through an operation that has a successful outcome provides a tremendous feeling of satisfaction."

Besides carrying a heavy surgical schedule, Roberts has been involved heavily in research, studying such areas as better ways to diagnose perioperative heart attacks and the relative value of techniques used to protect the heart during open-heart surgery.

Roberts is certified by the American Board of Surgery and the American Board of Thoracic Surgery. He is a member of numerous professional societies, including the American Medical Association, the Association for Academic Surgery, the Society of Thoracic Surgery and the American College of Surgery. The co-author of several medical book chapters and many journal articles, he is the editor of two books, on coronary artery bypass graft surgery and adult cardiac surgery.

One of the issues that Roberts plans to address is the Hospital's role in heart transplantation. According to Steven M. Cooper, clinical administrator for surgical services, the subject of transplantation is high on the new cardiac surgeon's agenda. "University Hospital certainly commands the broad variety of resources needed for such a procedure, and now that Dr. Roberts has joined us, we are closely studying the matter."

"From a clinical point of view," said Roberts, "the results from the few medical centers now doing heart transplants prove that these procedures are no longer an experimental form of therapy. These selected centers are achieving one-year survival rates of 80 to 85 percent, which is very impressive."

"This hospital has a solid record in the overall treatment of coronary and valvular heart disease, so it makes sense that transplantation be considered for an expansion of clinical services. But if we are going to be successful in this project, we have to make a major institutional commitment to it, as well as obtain the needed state health-planning approval." □
Reducing Your Risk: 
No Great Mystery 
About How To Do It

HOW does someone go about reducing her or his 
risk of heart disease?

There's no great mystery about it, said Joseph 
Stokes III, M.D., a member of UH's Section of Pre­
ventive Medicine and Epidemiology.

"There are only about nine or 10 important risk 
factors for heart disease," said Stokes, who also is a 
professor of medicine at Boston University School of 
Medicine. "And most of these can be measured objec­
tively. It's not something that requires a long ques­
tionnaire, or insights into your psyche. If we know 
certain basic things about you—your age, your smok­
ing habits and so on—we can roll them together and 
come up with a risk profile."

Stokes emphasized there are some risk factors that 
cannot be altered. Heart disease is an affliction of the 
middle-aged, and no one has yet discovered how to 
roll back the years. It also is about four times more 
common among men than women under 45 years of 
age, and gender obviously is beyond an individual's 
control.

On the other hand, there are some risk factors that 
can be controlled. Included are the "big three"— 
smoking, hypertension, and cholesterol and other fats 
carried in the blood.

What follows are recommendations from UH pre­
vention experts on the best ways to reduce the risk of 
heart disease. The steps are listed by their value in 
cutting heart-disease risk, and by how readily an indi­
vidual can carry them out.

• Quit smoking. This not only cuts the risk of heart 
attacks in half, but also confers immediate benefit: 
Studies indicate that a person who quits smoking is in 
less danger of sudden death due to a heart attack al­
most from the moment the last cigarette is snuffed out 
than is a comparable person who hasn't dropped the 
habit.

• Treat hypertension. If you have high blood pres­
sure, it can substantially raise your risk of a heart at­
tack. The high point of the normal range for diastolic 
beats—90. If your blood pressure is above that 
level, see a doctor. With the medications available to­
day, even very high blood pressure can be brought 
down to, or very near, the normal range.

• Change your diet. Over much of this century, 
Americans have tended to consume too many fatty 
foods—butter, red meat, eggs—and the result has ex­
cessive cholesterol in the blood. Although lowering 
cholesterol is somewhat difficult, emphasizing carbo­
hydrates like breads, potatoes and other vegetables, 
and getting protein from such non-fatty foods as fish, 
poultry and various types of beans, helps. This ap­
plies, noted Stokes, even to thin people, if they con­
sume a lot of fats.

• Get regular exercise. The role of exercise in reduc­
ing heart disease risk may have been over-emphasized, 
said Stokes, but it still helps. For one thing, exercise 
- aids in keeping pounds off. It also strengthens the car­
diovascular system. "We think that exercise can be a 
valuable part of a comprehensive program of risk re­
duction," said the prevention specialist. "It should not 
be relied upon, though, as the sole means of prevent­
ing heart attacks."

There are other strategies, said Stokes, but none 
that confers as many benefits as these four. He noted, 
for example, that reducing stress, while useful for any 
one who suffers from such stress-related problems as 
insomnia, does not do much to reduce heart-disease 
risk. "We think stress plays a relatively minor role in 
coronary heart disease and hypertension," said Stokes.

The Evans Medical Group—the private practice 
group made up of physicians who are on the staff of 
UH and are faculty members of Boston University 
School of Medicine—is strongly committed to the 
practice of preventive medicine. The approach taken 
by the Evans Group physicians emphasizes com­
prehensive care on a continuing basis, with the physicians 
dealing with patients' individual lifestyles.

For more information, contact the Evans Medical 
Group, Fifth Floor, 720 Harrison Ave., Boston, Mass. 
02118. The phone number is 617/247-6660. □
Mending Mind And Body

An innovative psychiatric program aims to overcome ‘invisible barriers’ to the delivery of inpatient care

UNIVERSITY Hospital was one of the first teaching hospitals in the nation to have an inpatient psychiatric unit, the first in Massachusetts to admit psychologists to its medical staff, and the first in Boston to have a biofeedback clinic.

With that history of leadership, it is not surprising to find that another innovative University Hospital psychiatry program is attracting national attention. Such is the case with the Hospital’s unique two-fold approach to inpatient psychiatry, a new program that not only cares for inpatients with psychiatric problems, but also treats medical and surgical patients who might need help with psychiatric difficulties.

Patients whose psychiatric problems interfere with their medical progress or contribute to their health problems are transferred, with the aid of a consultation and liaison service, to the Psychiatric Unit.

The Psychiatric Unit at University Hospital is a 24-bed unit directed by Tommy Sellers, M.D., and Maureen Smith, M.D., associate director, with a fairly even number of patients who are admitted directly to the unit and patients who are transferred there from medical or surgical units. Sellers concerns himself mainly with those patients admitted to the unit, primarily from outpatient referral sources; Smith is responsible for the patients referred from other patient units in the Hospital.

Smith’s responsibility includes close interaction with the Consultation and Liaison Service, and being involved in making rounds on the various medical and surgical floors of University Hospital. Smith and the other psychiatrists in the liaison service learn through their consultations on rounds of patients who might benefit from psychiatric therapy.

Transfers ‘quite acceptable’

The Psychiatric Unit has managed to break the invisible barriers that have isolated such units in the past. Those barriers kept psychiatric problems contained in a single unit, and staff psychiatrists were tied to that unit. But now, according to Smith, “it is seen as quite acceptable at University Hospital for patients with chronic illnesses to be transferred to the Psychiatric Unit so that their emotional problems can be more effectively addressed.”

Donald Korst, M.D., associate chief of the Evans General Internal Medicine Group, agrees. He sees the Psychiatric Unit as one that “enables University Hospital to provide patients with complete care.” Korst said that with many patients, it is often only after they have been admitted to a hospital for medical reasons that it becomes apparent that their illness also may be due to psychiatric problems. “As soon as medical treatment is stabilized,” explained Korst, “the Psychiatric Unit is available, so that the patient’s psychiatric needs can be dealt with while medical needs continue to be managed.” Korst added that in some instances patients might have to go to two separate hospitals in order to receive the same treatment that University Hospital can provide in one unit.

Consultation allows for provision of total care for the patient

According to Korst, transfers also are made on the recommendation of the General Medicine Consultation Service. It is the responsibility of the general internist to look at the total care of the patient. “Rather than dealing with specific problems—the lung, the heart—we look at the total workup, the total patient care,” said Korst. In the medical units, a senior resident works on the patient consultations, examines the
Donald Korst, M.D., associate chief of the Evans General Internal Medicine Group, reviews a patient's progress with Maureen Smith, M.D., associate director of the UH Psychiatric Unit.

patient as a whole and determines whether that person has any problems in addition to those for which he or she was admitted.

Patients don't have to be transferred to the Psychiatric Unit by the Section of General Internal Medicine in order to be part of Internal Medicine's rounds. Korst, a professor of medicine at Boston University School of Medicine, explained that patients admitted directly to the Psychiatric Unit are examined by the psychiatry staff, including a physician's assistant who works in conjunction with the Unit's physicians to provide the same daily care that is found in any other unit of the Hospital. "If medical problems are discovered, a physician from the General Internal Medicine Section will be called in, and he or she may write orders for that patient's specific needs. This not only allows us to follow patients with infections and other medical problems, but it enables us also upon discharge to keep up the patient's treatment in our role as primary-care physician," he said.

Daily activity plans

The staff of the Psychiatric Unit works closely with the patients, incorporating the various consultations and physician orders into daily routines. Mornings begin with working rounds, and staff discussion on the function reports of each patient. These discussions are followed by individual patient meetings to plan daily activities. A variety of activities, ranging from primary examinations to group therapy, are incorporated into each patient's day.

The staff members of the Psychiatric Unit are with the patients throughout the day, leading them through therapy and sitting with them through consultations. They also meet with other staffers to discuss further plans and to assess the individual psychological characteristics of each patient through what is known as a biopsychosocial systems approach: looking at such contributing elements as the patient's family situation, social environment and life stresses. Without a consci-
entitious staff, the Psychiatric Unit’s concept of interdisciplinary care would be ineffective, Sellers pointed out.

As a part of University Hospital’s Division of Psychiatry, the Psychiatric Unit has a close working relationship with the Division’s Department of Biobehavioral Sciences.

The unit functions not only as a general inpatient service capable of treating patients with depression, psychosis, schizophrenia and anxiety, but also as a unit that specializes in the treatment of patients with psychosomatic, neurobehavioral or somatopsychic problems. This dynamic behavioral medicine approach allows the staff first to conceptualize the psychologically conflicting areas that contribute to the patient’s problems, and then to utilize not only the classical treatments used on inpatient services, such as psychotherapy and medication, but also to integrate behavioral therapies and biofeedback into individual patients’ treatment plans when indicated.

Sellers, an assistant professor of psychiatry in the School of Medicine, explained that some symptoms and maladaptive behavior can be reshaped through such methods as biofeedback or behavioral therapy. “Let’s say a patient is admitted for severe depression with intolerable tension headaches as a second symptom, or ‘depressive equivalent.’ In addition to psychotherapy, medication or more classical treatments, a patient also may be offered biofeedback, whereby muscle tension is monitored through the use of electrodes. The patient, by reading the display message on the monitor, is taught to control this muscle tension and even may be helped to understand in which situations his muscles became tense. Now the patient not only can be free from headaches, but also has a sense of control over his or her life.” Sellers said biofeedback could aid such patients in the future by helping them to control their anxiety and thus to avoid falling back on the “helplessness and hopelessness” that was contributing to the depression to begin with.

While there are various approaches to behavioral therapy, according to Sellers, it basically deals with constructing a behavior plan for the patients to follow and then helping them to incorporate the plan into their daily routine. For example, if a patient had a phobia of germs that made him constantly wash his hands, following an understanding of why he felt the need to persist in this behavior, the plan could begin with an agreement that he would not wash his hands. From there, the patient would proceed to get his hands dirty again and again, and experience the feelings associated with this activity. “We might carefully expose such patients directly to what they find frightening and, with constant reassurance, help them to face and overcome that fear,” explained Sellers.

Smith said behavioral therapy gives patients a more positive image of themselves when they achieve the goals that the behavior plan set up for them. She also added that with patients who are confined to their beds, such a plan “helps them tolerate the bedrest and even just the daily act of living.”

Sellers said the Psychiatric Unit at University Hospital has made great strides in breaking out of the mold that is typical for such units, and, in fact, is becoming a role model for other hospitals to follow. At the same time, the staff members aim to continue strengthening the unit’s medical facilities, making themselves even more accessible to patients with critical illnesses. “Acceptance of the unit can only grow as the character of the unit becomes more medical,” said Smith.

UH group providing national training in stress management

In response to increased demand, the Department of Biobehavioral Sciences of the UH Division of Psychiatry, a national leader in the field, this year began bringing its stress-management training course to health professionals around the United States. Prior to the expanded effort, the Hospital’s Biobehavioral Sciences Clinical Unit held the week-long program at the Boston University Medical Center campus.

As the first hospital to have a Department of Biobehavioral Sciences, University has been in the spotlight in that field. According to Alice Nichols, M. Ed., director of the National Training Programs, the Department has been successful in accommodating physicians, psychologists, nurses and social workers who wished to attend their behavioral medicine training programs in Boston. “Now,” she said, “health professionals are seeking us out to bring our new techniques and training programs to their hospitals as well.”

Nichols said many illnesses often can be directly related to stress. The behavioral medicine training course for health professionals addresses such stress-related disorders as migraine and tension headaches, temporomandibular joint pain, hypertension, Raynaud’s disease, neuromuscular disorders, cardiac abnormalities and pain management.

The course is a combination of instructive lectures, presented by guest lecturers and members of the Biobehavioral Science staff, and “hands-on” training that is designed to introduce health professionals to the behavioral skills necessary for diagnosis, intake and intervention in stress-related problems.

Mary E. Malloy is assistant editor of University Hospital.
BRA grants tentative designation to SETSA development project

South End Technology Square Associates, a nonprofit corporation fostered by University Hospital trustees to stimulate development and increase employment opportunities in Boston's South End, has received preliminary city approval for a development project that would include office and retail space, a hotel, and a parking garage. The Boston Redevelopment Authority Board voted unanimously to approve tentative designation to the South End partnership to develop a parcel of land on Albany Street, across from the Hospital and Medical Center.

With BRA approval, University Associates, a development team composed of SETSA and principals of Carpenter & Company, a major Boston development firm, can now secure the financing for its proposed four-phase, $84-million development project. SETSA is composed of representatives of area institutions, businesses and residents.

Other institutions involved in SETSA, in addition to University Hospital, are Boston University, Boston City Hospital and New England Nuclear Corporation, a subsidiary of DuPont. The land designated for the project is owned by the City of Boston, but was designated in 1967 as the site for future facilities that support the needs of Boston University Medical Center.

The Hospital and the Medical Center support the project because of its potential to upgrade the area and to create new jobs. University Associates estimates the development project will create more than 2,100 permanent jobs.

The four-phase project, to be developed over a six-year period, would include an 180,000 square-foot office building, parking facilities and a hotel. In addition, retail space would be located on the first floor throughout the structure.

UH shares its modern ECG service with Boston City, Carney hospitals

Patients in need of having their heart function checked via an electrocardiogram at neighboring Boston City Hospital and Dorchester's Carney Hospital now have immediate access, through an innovative telephone hookup system, to modern ECG technology at University Hospital.

In the special shared-service program, physicians at BCH and Carney, which are both teaching hospitals of Boston University School of Medicine, can conduct ECGs on patients using portable ECG carts and editing stations, similar to those used at University Hospital. The equipment then transmits the ECG by telephone to University Hospital's mainframe computer, where it is recorded, interpreted, stored and sent back to the subscribing hospital. A written report...
also is sent to the hospitals for individual physician interpretation and patient records.

The service, one of only a few in the Northeast, began two years ago when University Hospital purchased a Hewlett-Packard ECG Management System. Shortly after the purchase, the Hospital enlisted Carney Hospital as a subscriber to the system, and then BCH was added last year.

The shared service allows Carney and BCH to have the same operational output as University Hospital, while saving substantially on the subscribing hospitals' capital outlay, since they pay University Hospital on a per-ECG basis only.

According to Wanda McGovern, administrative coordinator for University Hospital's Section of Cardiology, the cost-effectiveness of University Hospital's shared service is timely in this cost-conscious era. By providing such a service to two area hospitals, McGovern said, University Hospital is allowing these institutions to take advantage of superior technology without having to make a major capital investment themselves.

Hospital receives approval for partial replacement program

University Hospital received approval from the Massachusetts Public Health Council in February for its partial replacement project. The approval, won after some 40 months of planning, gives the Hospital permission to replace all of the inpatient units presently located in its oldest buildings.

A new clinical facility, designated the Q Building, will be constructed on the Medical Center campus to house the majority of the replaced beds. The remaining beds will be transferred to the Preston Family Building, and the medical beds currently in the Preston Building will move to the Evans Building. The maximum cost of the project, $65.9 million, is expected to be borne through a combination of equity, furnished by University Hospital, and the sale of bonds.

131 surgical beds

In addition to the 131 surgical beds that will be relocated to the new facility, the Q Building will house a 16-bed Surgical Intensive Care Unit; operating and recovery rooms; diagnostic radiology; the admitting department; a pharmacy; a consolidated materials-management unit and common areas, including a central lobby, gift shop and coffee shop.

The Hospital's partial replacement project also will provide for the relocation of all ambulatory surgery to the Booth Ambulatory Surgery Unit, operated by University Hospital and located at Boston University's Goldman School of Graduate Dentistry; renovation of the Evans Building and Preston Family Building, to permit additional patient-care consolidations; minor renovations of the Hospital's existing kitchen; general equipment replacement or addition; and the demolition of Vose Hall, a Hospital building that is beyond repair.

The Q Building will be built on what is now a Hospital parking lot. The structure is to be linked directly to the Hospital's Health Services Building, and an elevator will be constructed to link the Health Services and the Preston Family buildings. Construction is scheduled to begin by the end of 1984, and will take about 20 months.

Hospital wins grant aimed at cutting unneeded lab tests

A Boston University Medical Center research group is in the process of beginning a unique project at University Hospital that may reduce laboratory testing by as much as 30 to 40 percent. Funded by a one-and-a-half-year $167,188 grant from Wood Johnson Foundation, the project will use computers to monitor laboratory test requests and to determine if such tests are appropriate.

The costs of laboratory tests account for approximately $25 billion of the nation's hospital costs each year and the number of tests has been rising. There is general agreement in the medical field that many of these ordered tests are either unnecessary or inappropriate, but any attempts to reduce the numbers of such tests have proved expensive and only temporarily effective.

Now, through University Hospital's Test Request Intervener and Modifier (TRIM) Program, a computer will analyze each laboratory request form and decide if the requested test should be performed.

Could be used nationally

According to Mark Moskowitz, M.D., an internal medicine specialist at University Hospital and co-director of the project, TRIM is designed to reduce over-utilization of clinical laboratories in an efficient and effective manner that would be acceptable to physicians. "We believe that if our trial program proves successful, the TRIM Program could be modified to fit the needs of hospitals across the country," Moskowitz said.

Working on the TRIM Program with Moskowitz will be Bernard E. Statland, M.D., chief of Laboratory Medicine at University Hospital. Statland first presented TRIM in an article printed in the February 1984 issue of Medical Laboratory Observer. Written in conjunction with Per Winkel, M.D., a visiting professor from Denmark, the article presented a three-tiered approach to lab test utilization, namely Test Request Audit Control (TRAC), Test Request Alert Program (TRAP), and TRIM.
NATIONAL LEADERSHIP

More UH staff named to national positions

University Hospital health professionals continue to be honored by their peers in specialty organizations. Since the last issue of University Hospital was published, the following UH staff members have been named to leadership positions by their fellow professionals:

Aram V. Chobanian, M.D., chief of hypertension and director of Boston University's Cardiovascular Institute: Chairman of the Heart, Lung and Blood Research Committee of the National Institutes of Health and a member of the Joint National Committee on Hypertension.

Alan S. Cohen, M.D., chief of arthritis and director of the Boston University Multipurpose Arthritis Center: President of the Massachusetts Chapter of the Arthritis Foundation and chairman of the International Affairs Committee of the American Rheumatism Association.


Haralambos Gavras, M.D.: Appointed to the Cardiovascular and Renal Study Section of the National Institutes of Health.

Paul A. Levine, M.D., director of Electrophysiology Laboratory: Member of the Executive Advisory Board of the North American Society of Pacing and Electro-physiology.

Marilyn Pires, R.N., M.S.N., rehabilitation clinical specialist: President-elect of the Association of Rehabilitation Nurses.

Thomas J. Ryan, M.D., chief of cardiology: President-elect of the American Heart Association.

R. Knight Steel, M.D., chief of geriatrics: President of the American Geriatrics Society for the 1983-84 term.

Marvelous Maureen McGovern

SINGER Maureen McGovern, whose musical hits include the theme from “The Poseidon Adventure,” was a double star for University Hospital this spring: She not only entertained at the Hospital’s Seventh Annual Gala Benefit evening, but she also made a special visit to the Hospital’s New England Regional Spinal Cord Injury Center, where she chatted with patients and staff and performed for them. The Hospital visit was covered live by Channel 4, WBZ-TV, Boston, and gave the NERSIC patients a preview of her performance at the Gala.
A double benefit for University Hospital: Singer Maureen McGovern, far left, performed at the Hospital's Seventh Annual Gala Benefit and gave a preview of that performance the evening before by singing for patients in the New England Regional Spinal Cord Injury Center.

Between songs, recording star takes time to chat with patients.

Below left, McGovern is interviewed by Channel 4 personality Joyce Kulhawik for a "Live on Four" broadcast from the UH New England Spinal Cord Injury Center.

Below, patients gather in Spinal Cord Center activity room to hear McGovern sing.
With Help
From Our Friends

PROFILES IN PHILANTHROPY

Throughout its 129-year history, University Hospital has been an innovator and a leader in medical care. In maintaining this leadership position, the Hospital has relied on a number of special people whose commitment has helped the Hospital to give life to the programs of our professional staff, to build new facilities and to develop and acquire the technologies needed to improve patient care. While the names of these helping friends have changed over the years, the spirit of concern and commitment they have lent to our programs has remained the same.

The commitment to enrich the quality of people's lives through philanthropy and voluntary service is vital to University Hospital. For this reason, and to encourage others to make their own commitment, we salute the special friends who will appear in this and future issues of University Hospital.

Peter J. Mozden, M.D.: Philanthropy a two-sided concept—you help others and enrich your own life

By Mary E. Malloy

Among the many individuals who have given much of their time and other resources towards supporting University Hospital and its efforts to continue to provide quality medical care and clinical research is Peter J. Mozden, M.D., head of University Hospital's Section on Surgical Oncology.

An act of philanthropy—being of service to others—is a means of preserving or creating something worthwhile, but it also is a necessary part of everyday life. These reasons, both of equal importance, explain why this busy surgeon chooses to devote much of his time and energies to such diverse causes as the preservation of the wilderness and the strengthening of institutions like University Hospital.

"Without philanthropy, hospitals could be a jeopardized species"

Help for the vulnerable

"Looking at and reflecting on the realities of life and its stresses, we become aware that many extremely worthwhile areas of our lives are frail, gentle and vulnerable. Only when an outer force can prevent the erosion and extinction of the aspects of life that we hold dear, does applied philanthropy become the answer," Mozden said.

"The other side of that concept," he continued, "is philanthropy as an institution that allows us to be of service to others, thereby enriching our own lives. It's healthful to see what you've been involved in come to fruition through creativity and philanthropy."

Mozden, who is a professor of surgery and an assistant professor of gynecology at the School of Medicine, believes there are a number of reasons people become involved with philanthropy. There are, of course, the practical reasons. According to Mozden, philanthropy is becoming increasingly important in solving practical problems. Nonprofit institutions, such as hospitals, or important traditions, such as the preservation of our natural resources, must be supported or they will fall by the wayside.

"In business," Mozden explained, "it's possible to get rid of the less productive things, allowing greater concentration for profit-making ventures. Hospitals, however, are not in business to make

'It's healthful to see what you've been involved in come to fruition . . .''
money, and thus cannot turn their backs on patients who need equipment or treatments that won't bring in a profit." Therefore, Mozden sees philanthropic support as vital to hospitals—particularly when an era of cost containment is so strongly upon them, and said "without the sensitive, philanthropic support of those individuals who have the ability to understand, hospitals could become a vulnerable, jeopardized species.

"One can't be involved for very long," said Mozden, "before he realizes that the intellectual aspects of philanthropy also are very real and rewarding." According to Mozden, it is a mind-opening and broadening experience in which "you begin to see another side of yourself and the people you are working with—a side beyond their usual image, one which represents the best of our civilization."

The need to help others

Mozden went on to explain how philanthropy fits into what he called the dimensions of life. "We all have work to do and we all need to take time to relax and play. But we also have a need to do good for others and this need to be of service should be a part of all our lives." Finally, Mozden noted the need to recognize life's stresses so that they can be understood and balanced. Philanthropy, according to Mozden, is similar to the exercise of meditation: "It can balance life's stresses by transporting oneself out of the day-in-day-out demands we encounter. It is too narrow a life to think only of oneself," he said, "to hide in a shell and not move beyond. One will suddenly realize that something is missing and what is missing is our inner need to be of service to others."

Mozden sees physicians as being in a unique position when it comes to understanding philanthropy because they are involved every day in serving others. "Physicians," Mozden explained, "can be especially sensitive to this need to do service because they already know the gratification they have received through the process of helping others. It's easy for physicians to participate because they are already involved."

Everyone should experience the exhilaration of seeing something born out of her or his selfless efforts, according to Mozden. He sees this as necessary not only as a means of balancing stress through a wholesome activity, but also to keep those things we cherish from disappearing.

"In this country, more than in any other, we enjoy our freedom and take it for granted. Here we can make our own place out of individual experiences. These freedoms, however, are slowly but surely disappearing because the traditions and institutions that support them are now being challenged. Individuals have to be willing to not only think about this and identify with it, but they also need to find solutions in the middle of an aggressive, progressive society that has little time for it."

There are both tangible and intangible rewards that come to those who involve themselves in philanthropic activities, Mozden noted. "The tangible rewards come from seeing a project or cause that we support come to fruition. The intangible rewards are more subtle and can best be ascribed as an inner feeling of quiet satisfaction and tranquility in knowing that we have done something, or lent ourselves to efforts that have made the world we live in a better place for others."

Special friends help the Hospital fulfill its mission

The principles that underlie philanthropic action are eloquently described by University Hospital on­cologist Peter J. Mozden, M.D., in the previous article. Those ideals are fulfilled in very concrete ways by a number of special friends of University Hospital, among them the Hospital's staff. Through their giving, the employees of University Hospital have allowed needed programs and equipment to become a reality—the essence of philanthropy in action.

Last year more than 500 University Hospital employees contributed to the 1983 Employee Giving Campaign, a combined appeal in support of the United Way and a
Hospital Project. The Hospital Project's goal in 1983 was to install automatic doors in the Evans Lobby, University Hospital's main entrance. An employee campaign committee selected this from several projects that had high priority but which could not be included in the Hospital budget.

In the past, people in wheelchairs and on crutches, ambulance attendants, people carrying packages, and any person with less than full strength, have had difficulty maneuvering through the lobby doors. Thus, the provision of automatic doors in the Evans Lobby will be of benefit to both the handicapped and the non-handicapped population entering University Hospital.

Altogether Hospital employees gave $43,639.74 to the Employee Giving Campaign in 1983 to complete the Hospital Project and to benefit the 176 member agencies of the United Way of Massachusetts Bay.

"For years patients have commented on the special quality of care that University Hospital employees help to provide," said Susan Siegel, manager of the Employee Giving Campaign. "The Hospital Project is visible proof that the employees do help in special ways."

The following area businesses helped to make the 1983 Employee Giving Campaign a success by donating gifts for incentive prize drawings, Siegel said. "We are proud to acknowledge their support:"

Aku Aku
American Repertory Theatre
Bailey's
Boston Bruins
Boston Celtics
Boston Shakespeare Company
Charley's Eating and Drinking Saloon
Copley Camera
Copley Plaza
Dini's Sea Grill
Elizabeth Grady Face First
Fabrications
57 Park Plaza
General Cinema
Huntington Theatre Company
Hyatt Regency

Institute of Contemporary Art
Jason's
Jimmy's Harborside Restaurant
Joyce Chen's
Maison Robert
Medieval Manor
Museum of Fine Arts
Museum of Science
New England Patriots
Park Plaza
Parker House
Richardson's Amusement
Sack Theatres
Scotch n' Sirloin
Stop & Shop
Top of the Hub
Wursthaus

Pathfinder: Key tool helps physicians to record body response

A sophisticated new tool to help physicians measure the body's nerve responses is the centerpiece of University Hospital's 1984 Annual Fund. The Nicholet Pathfinder II, an electrophysiologic computer system, is able to monitor, record and store evoked potentials—such as the body's responses to visual or auditory stimuli—in the quickest and most reliable manner. This important new tool will play a crucial role, for instance, in evaluating cognitive functions and in a number of intraoperative procedures.

Although the equipment was originally requested by the Department of Neurology, its compact, mobile features make it accessible to such other University Hospital departments as anesthesiology, intensive care, neurosurgery, otorhinolaryngology, psychiatry, rehabilitation medicine and urology.

Evoked potentials, which are monitored responses received by constant nerve stimulation, are being used in many clinical applications. Neurologists use evoked potentials to diagnose and treat nerve damage. Such abnormalities as tumors are sometimes not detectable by any other clinical method.

The ability to measure evoked potentials in the operating room allows physicians to constantly monitor nerve functions during an operation. In the past, certain surgical procedures involving the spinal cord required that the patient remain awake so that these same functions could be monitored.

The Pathfinder also can be used in the Hospital's intensive care units to monitor coma and document brain death.

Evidence obtained through evoked potentials is extremely valuable in the field of psychiatry, where it provides a measure by which psychiatrists can judge the effectiveness of drug therapy.

All 1983 UH Annual Fund Donors were invited to an Open House on Jan. 18, 1984, to celebrate the installation of the new Linear Accelerator Treatment Suites in University Hospital's Department of Radiation Medicine. Now University Hospital has the finest state-of-the-art equipment to match its already highly regarded Radiation Medicine staff.
Audrey and Max Goldstein, second and fourth from left, recently established the Max and Audrey Goldstein Cancer Care Fund at University Hospital. The C-5 nursing staff turned out to honor the Goldsteins, who started the fund in appreciation of the care Audrey received while a patient on the floor. Standing with the Goldsteins, left to right, are: Peter J. Mozden, M.D., chief of surgical oncology; Maureen Kavanah, M.D., a surgical oncologist; Bernadette McKinsey, R.N.; Eloise Washington, nursing assistant; Andi Faustine, R.N.; Denise Parks, nursing assistant; Marguerite Daveron, R.N.; and Cathy Beaupre, R.N., C-5 head nurse.

The interdisciplinary nature of the Pathfinder, and the impact such state-of-the-art technology will have on patient care, have made it the target for the 1984 University Hospital Annual Fund. The Pathfinder is a good example of the extras made possible through contributions because it is a piece of technology that enables University Hospital to provide levels of treatment not available at the level of the community hospital.

Over the years the Annual Fund has raised money to help purchase new equipment like the Pathfinder and to otherwise meet needs that ordinarily can't be accommodated in a tight hospital budget. Annual Fund gifts come from a wide range of people, including employees, trustees, corporators, former patients, their families and other friends.

The 1982-83 Annual Fund focused on the needs of University Hospital's Department of Radiation Medicine and contributions went towards the installation of two linear accelerators.

President's Council: Special friends help UH meet its mission

The University Hospital President's Council, formed only a year ago, has grown in both numbers and involvement. The purpose of the President's Council is to recognize and involve those individuals who, by making major gifts to the Hospital on an annual basis, have shown special interest in helping UH to fulfill its mission. The Hospital offers a special program to maintain a close and informed relationship with each Council member. For more information regarding membership in the President's Council, contact Michael Valentine, director of Development, at 247-5590.

The following have become members of the President's Council since October 1984:

Ruth Bakst
Desmond H. Birkett, M.D.
Henry Burkhards, III
Rev. Laurel A. Burton

Richard Bush, M.D.
Aram V. Chobanian, M.D.
Anne R. and Roger L. Clifton
Jay and Louise Coffman
Saul Cohen, M.D.
Mrs. Claire Daniels
Jacqueline Dart
Harvey E. Finkel, M.D.
Phyllis and Murray Fred
Max and Audrey Goldstein
Bernard L. Huang, M.D.
Maureen T. Kavanah, M.D.
David H. Knight
Howard M. Lebowitz, M.D.
Frank and Judith LoGerfo
Dr. and Mrs. Bruce W. Lowney
Dr. and Mrs. Irving M. Madoff
James Melby, M.D.
Joseph P. Moore
Mr. and Mrs. James H. Orr
Mr. and Mrs. Stephen Paine Sr.
G. Richard Paul, M.D.
Marguerite A. Piret
Thomas J. Ryan, M.D.
Daniel S. Sax, M.D.
Enid and Melvin I. Shapiro
Sidney Shuman
George E. Slye
Edward L. Spatz, M.D.
H. Emerson Thomas, M.D.
Philip S. White, M.D.
David Yeston
Neil Yeston, M.D.
Anonymous (3)

(as of 4/11/84)
It All Began In Room 17
Chaplain Emeritus Potter tells trustees of UH roots, and its growth on filled land near ‘the Boston Neck’

UNIVERSITY Hospital’s trustees, assembled in December for their annual meeting in Hiebert Lounge, 14 stories above the sprawling Medical Center campus, were transported from that scene back more than a century to the Hospital’s roots: a small space called Room 17, one flight up in what is now Boston’s Tremont Temple Baptist Church.

Hospital Chaplain Emeritus Leicester Potter, in a rich recounting of the Hospital’s early history, took the trustees back even further than that one-room clinic of 1857:

Gesturing at the window walls on the north and south sides of the Hiebert, he said, “Look out of these windows: thousands of buildings, a spiderweb of streets; now look out the windows on the other side of the room: more houses, more land, more evidences of industry. But if by magic we could go back to when Boston was founded, and look out in the same direction, we would see nothing but water on this side, nothing but water on that side. Boston came into being as an island. And where University Hospital stands today was then under water, offshore from that island.

“Why do I give you a course in geography? Because I can’t talk about this Hospital unless I talk about the growth of the city. For as the city grew, it nurtured this Hospital. The story of the Hospital is a story of people—not only the people who worked here, but also the people who were and are part of the community, for you can not separate the two.”

Rev. Dr. Potter’s talk about the early days of the Hospital in one sense was his valedictory to UH, for he had been called that day before the trustees to be honored for his 39 years of dedicated and innovative service. However, in another sense, it was not Rev. Dr. Potter’s farewell: The former chaplain and director of Pastoral Care and Education retired last fall,
Scene of a patient unit in the Talbot Building, the Hospital's original structure, circa 1885. The building is now used for administrative purposes.

but continues to serve University Hospital as the resident staff historian.

Some brief excerpts from Rev. Dr. Potter's talk follow.

Filling in the 'Boston Neck'

"Boston's gradual transition from being a farm community to its later status as an important town was a great change that could be seen in reports that, in a single week, some 1,200 ships could be seen coming and going in this seaport.

"Boston grew and flourished: stagecoach after stagecoach brought people here 'over the Boston Neck'—which was the present Washington Street, bordered on each side by water. The island that was Boston at that time was in the shape of a pear with several bites out of it. The pear's stem was the Boston Neck, connecting Boston with Roxbury and the rest of the mainland.

"The Boston shoreline at that time was what now is Washington Street and Harrison Avenue. But over the decades, the 'filling-in' of Boston continued, to the point that when the Talbot Building—the Hospital's first structure—was opened in 1876, the Harbor shoreline was where Albany Street is today. The mural in our Interfaith Chapel shows sailing vessels tied up at a shipyard behind the Talbot Building. Fort Point Channel in those days still was being used by great sailing vessels bringing lumber from Maine."

From clinic to Hospital

"The Homeopathic Medical Dispensary, which was to become the University Hospital of today, began on April 20, 1857, in a rented room downtown on a site that first held a Masonic temple, then was a federal courthouse, and today is the location of the Tremont Temple Baptist Church. There, in Room 17, one flight up, some 16 physicians extended free medical care to Boston's needy. However, as the clinic grew more active, space became a problem; the trustees raised more than $17,000 and purchased a three-story building on Burrough's Place (behind the present Wang Center).

"The Massachusetts Homeopathic Hospital, as the trustees named it, opened its doors in that building on
The hallmark of this Hospital has always been top-notch nursing care.

When World War I began...the physicians and nurses of the Hospital were quick to respond...

Jan. 23, 1871—and the 16 beds were filled immediately. And, just as immediately, the trustees began looking for a larger building.

"While the Hospital was looking for a new building site, the 25-year-old New England Female Medical College, which was plagued by financial difficulties, was transferred to Boston University, becoming Boston University School of Medicine. The medical college, the first women’s medical school in the world, had earlier erected a new building here in the South End, between East Concord and Stoughton Streets.

"Because the Hospital and the new School of Medicine were founded, staffed and supported by many of the same leading Bostonians, the Massachusetts Homoeopathic Hospital chose to erect its new building next to the School. The Hospital building, constructed on land bounded by East Concord, Albany, and Stoughton streets, was designed by William Ralph Emerson, and cost $48,966. The red brick structure, which opened on May 4, 1876, was named for Israel Tisdale Talbot, M.D., the Hospital’s first surgeon-in-chief and the School of Medicine’s first dean. The Talbot has been cited as a fine example of the classically ornamental Queen Anne style of architecture.

"The new building had 38 beds, a vestibule that opened into a main hall, a reception room, and offices for the superintendents on the first level. An apothecary was located next to those offices. Rooms for nurses and physicians were located in the attic. In 1884, a surgical wing was added, and the first of two amphitheaters was built. Until then, all operations had been performed on Saturdays in the medical school across the courtyard. Saturday was the day the tables in the school were not being used by students doing dissections."

The nursing school opens

"A school of nursing, one of the first in New England, was opened by the Hospital in 1885, and the first graduation—for four nurses—took place in 1887. The hallmark of this Hospital always has been top-notch nursing care. Since the school was founded in 1885, our nurses have played an important role here in the Hospital but also nationally in the development of high nursing standards.

"The Massachusetts Memorial Hospitals Nursing Alumnae Association was formed in 1895, and its membership eventually exceeded 2,000. This group of women was responsible for the change in nursing
19th-century engraving shows original School of Medicine building and the Talbot Building: "In 1884, a surgical wing was added (to the Talbot)...Until then, all operations had been performed on Saturdays in the medical school...Saturday was the day the tables in the school were not being used by students doing dissections."

working hours from 24 hours a day to 12 hours. Later, they implemented the change to the current 8-hour shift.

"Although the School closed in 1962, members of the MMHNAA still play an active role here at University Hospital: for instance, in their tremendous support for the building of the Hospital's Interfaith Chapel. They will continue to have an important role as they assist the Hospital of the future."

Nurses, physicians go off to war

"When World War I started, the nation's large hospitals were asked to help meet the military's medical needs, and the physicians and nurses of this Hospital were quick to respond. By May 1917—just a month after war was declared—the trustees and staff had accepted the challenge and opened a drive for $30,000 to purchase equipment: That goal was met within 10 days. In June, the Hospital's unit—called Base Hospital 44—was formed. Some 70 physicians volunteered, but only 22 were selected, as the others would be needed to run this Hospital. A chaplain was appointed, and 65 graduate registered nurses were chosen. Some 200 enlisted personnel later joined Base Hospital 44, as the unit trained at Fort Dix, N.J.

"Although after the training period there were a number of delays in getting the unit off to Europe, our Hospital's personnel made good use of their time: Our physicians helped to examine the newly drafted soldiers arriving at Fort Dix and Camp Greenleaf. It is reported that during the latter part of May, they examined more than 16,000 men, working day and night until the last physical was completed.

"In July 1918, members of Base Hospital 44 arrived in Pougues-les-Eaux, a small resort in the middle of France. Hotels and chalets in the area were adapted to the Base Hospital's use. By August, the Base Hospital was up and running. The first patients, soldiers who had been wounded in the Battle of Pougues, arrived and were treated on August 10.

"By October, the daily census of Base Hospital 44 was well over 1,700, a figure that represented not only an array of war wounds, but also an epidemic of influenza."

The Chaplain described the growth of the Hospital buildings—the Robinson, the Evans and the Collamore—and spiced his talk with stories of some of the people who made those buildings possible. His anecdotes about some of the Hospital's more colorful personalities helped to round out this recollection of the Hospital's vibrant early history. Chaplain Potter currently is sifting through his considerable collection of University Hospital lore with the goal of compiling the official UH history. □
Former chaplain honored for 39 years of service to University Hospital

The Rev. Dr. Leicester R. Potter, retiring last December after 39 years of service to University Hospital, was honored with the Hospital's Distinguished Service Award at the 129th Annual Meeting of the Hospital Corporation. Hospital administrators, trustees, corporators, medical staff and friends paid tribute to the former chaplain, acknowledging his lasting contribution to the mission of the Hospital.

Additional tributes to the chaplain, an innovator in hospital pastoral-care training, accompanied the Distinguished Service Award. A resolution was presented to Rev. Dr. Potter by John F. Cogan Jr., chairman of the Board of Trustees, establishing the Leicester R. Potter Pastoral Fund. The fund, a permanent endowment to support the work of the Department of Pastoral Care and Education, was started by Hospital trustees, the UH Aid Association and the Massachusetts Memorial Hospitals Nurses Alumnae Association.

A pioneer in his field

According to Cogan, there were several reasons for establishing such an endowment, among them the former chaplain's unique position as the nation's first resident staff chaplain, his years of counsel and assistance to patients, staff and trustees of University Hospital, and his pioneer work in clinical pastoral education. The resolution, which cites these accomplishments, presently hangs in the Hospital's Interfaith Chapel.

University Hospital's chaplain emeritus also was honored with the Leicester Potter Pastoral Fellowship, established by funds from an anonymous colleague to provide financial support to a student in the Hospital's Pastoral Education Program. A plaque bearing the name of Janet Reed McWalter, the first recipient of the fellowship, also is on display in the Chapel.
"With some help, an independent man stays that way—at age 89"

**John Moore’s story**

For disabled elderly persons who are determined to remain independent, 89-year-old John P. Moore is an inspiration.

With the active support of the Home Medical Service at University Hospital, Moore, who lives alone, has been able to care for himself despite four major operations over the past 13 years.

"The Home Medical Service staff has helped me after each operation. Ever since last June and July, when I had two big operations for cancer, they've especially been a big help. In April, for example, I completed five weeks of radiation therapy at University Hospital and they provided me with transportation there five days a week. They've also set me up with someone who cooks and shops for me, and someone who cleans my house.

"I'll be 90 in July. Because I live alone, I think I'm going to need the help of Home Medical Service on a regular basis from now on."

But Moore—one of Boston's 900 homebound elderly and disabled persons who remain independent because of the medical and other essential services they receive from Home Medical and its affiliated agencies—is one who always has demonstrated a fighting spirit, surviving in the face of high odds.

What else could be said of a man who, as a merchant seaman, served on four ships that sank during fierce storms and on another that blew up after hitting a floating mine?

Yet John Moore, fighter, survivor, also is a caring man, who through sheer will finds the energy to visit other Boston shut-in elderly people.

John Moore not only is a patient of Home Medical, but he also is a trusted advisor: He often attends meetings of the Home Medical staff, which includes physicians, nurses, social workers, secretaries, senior medical students, and he offers valuable suggestions on the program.

John Moore shares a large part of the credit for his energy, determination and independence with the staff of the Home Medical Service:

"They've done an incredible amount for me," he said. "I couldn't get better treatment anywhere in the world."
'It All Began In Room 17':
The Hospital's Early Years

The Interfaith Chapel, the focus of religious faith at University Hospital, also is a strong link both to the history of medicine and to the history of the Hospital itself. "It All Began In Room 17," an article beginning on Page 36 of this issue, highlights events during the early days of the Hospital, as recounted at the annual meeting of the UH trustees by the UH chaplain emeritus, Rev. Dr. Leicester Potter. The Chapel was the inspiration of Rev. Dr. Potter and, according to him, "was built with money donated by the people who are University Hospital."

The stained-glass windows above look out upon the Hospital's courtyard. They depict a variety of spiritual scenes related to the ministry of healing: Moses praying for his sister; Elisha healing a child; Hippocrates healing a young man; the Good Samaritan; the Apostles Peter and John and a crippled man; and the Jewish philosopher Moses Maimonides. Another set of stained-glass windows is dedicated to the hundreds of people who work at the Hospital in a broad range of vocations, all vital to the modern ministry of healing. One panel honors the clergy, another highlights the nursing profession, and a third focuses on physicians. All three panels carry symbolic representations of other professions and trades that support the Hospital's healing function. Another window commemorates the generosity of Arthur T. Dooley, an executive of the S.S. Pierce Company for more than 40 years, who made the stained-glass windows possible. Also honored in the windows is the Massachusetts Memorial Hospital Nurses Alumnae Association, whose members set up the fund that made the Chapel possible.

Rev. Dr. Potter is shown here at left examining a mural that covers the rear wall of the Chapel with illustrations highlighting the Hospital's 129-year history. The mural, executed by James J. McGurl of Quincy, Mass., reviews the Hospital's rich heritage through a series of vignettes. Other scenes from the mural are shown on Page 38.