1967

**Scope: v. 1, no. 1-8**

Schlang, Henry A.

Boston University

Boston University Medical Center. Scope, volume 1, number 1-8. 1967-1968.
Archived in OpenBU at http://hdl.handle.net/2144/20900.
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John Dryden

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1968 will mark forever an exciting and dramatic year in the history of the School of Medicine. Extensive changes have been evolving in the curriculum, and the space in the Research Building has been increased by three additional floors to a total of ten. It is difficult to believe that eight years ago this building did not exist. It is even more difficult to imagine how the School functioned as well as it did in the absence of such a building.

Now, in September, 1968, the first- and second-year classes have begun to occupy the new fourteen-story Instructional Building, which, joined with the Research Building, forms an impressive and modern medical school complex standing in sharp contrast to the old and inadequate plant which has long outlived its usefulness.

The new building will permit an increase in the student body to four hundred students. There are home base laboratories for students and special areas for student activities. There are new and attractive departmental offices and additional research space for the basic science departments. Included also is a new medical science library which will represent a tenfold increase in space, an increase in volumes to 100,000 and periodicals to 1,600, with adequate and inviting study and reading areas.

A new sense of excitement pervades both the student body and the faculty. Some of both wander about the new Instructional Building with expressions of disbelief.

In time, the new facilities will be accepted as part of everyday living; but, it is already clear that life for everyone identified with the School of Medicine will now continue at a level which will far exceed the productivity and accomplishments of the past.

At the request of Dean Franklin G. Ebaugh, Jr., Associate Dean Henry J. Bakst, contributed this salute to the new Instructional Building in its first months of use.
Internationally known for its distinguished work with the emotionally disturbed infant and preschool child, the James Jackson Putnam Children's Center helps its young patients within the friendly shelter of a century-old mansion in the Roxbury District of Boston. Lilliputian-size patients entering its massive front door with the extra-high doorknob consider it their "Special Nursery School" as they explore the rambling 41-room building, with its comfortable therapy offices, sunlit nursery school rooms, and garden playground.

Since its inception in 1943, Putnam Center has provided specialized training for hundreds of physicians — child psychiatrists and pediatricians — psychologists, social workers, nurses and teachers from most states of the Union and many foreign lands. The alumni of its training programs have provided leadership in child psychiatry, helping children throughout the entire world.

The Department of Child Psychiatry is sharing in the very substantial growth which characterizes the Boston University School of Medicine's Division of Psychiatry.

This growth process is reflected in plans and programs for the expansion of a variety of services to the children in our geographic area, in the development of new research programs in child development and child psychiatry, and in major changes of the training and teaching programs for fellows in Child Psychiatry, residents in Psychiatry,
medical students, Psychology trainees, and other students.

It is in this context of growth and expansion that we look forward to the opportunity of working closely with the staff of the James Jackson Putnam Children's Center and welcome their participation in the implementation and integration of these programs.

With its renown as a research and clinical center and its long history of work in the area of emotional development of young children, the Putnam Center is in a position to contribute substantially to these variegated programs.

Old professional ties give strength and promise to this new affiliation: Dr. Samuel Kaplan, Associate Director of Child Psychiatry at B.U. was for many years Associate Director of the Putnam Center; Dr. Eveoleen Rexford, B.U. Director, was a staff member at Putnam for six years following its establishment. Other B.U. staff members such as Dr. Pierre Johannet and Anna Wolff were associated with the Putnam for a number of years and Dr. Roy Briggs received part of his professional training there.

Dr. Eveoleen Rexford, Director of Child Psychiatry, has worked out a specific mechanism for the mutual implementation of our programs in the B.U. Child Psychiatry Council. Representatives of the staff of the Putnam Center now join with those of the Douglas A. Thom Clinic, the B.U.-B.C.H. Child Guidance Center and the supervisory and training staff of the B.U. Department of Child Psychiatry in a process of planning for the evolution of integrated programs and services, training and research. At the monthly meetings of this Council, detailed plans presented by the subcommittees in each of these areas are reviewed and eventually developed into specific programs of action in which the combined talents of all these child psychiatric facilities are utilized.

A specific immediate illustration of the process is the development of a plan for a series of three professional meetings for the current academic year giving each clinic the opportunity to acquaint the staffs of the other facilities with a central aspect of the ongoing clinical work. These meetings will be open to the general psychiatric communities and will provide an important meeting for acquainting our colleagues and future trainees with the exciting developments in our facilities.

We all very much look forward to an increasingly close collaboration with respected and esteemed colleagues of the James Jackson Putnam Children's Center for the mutual enrichment of the professional contributions from all of our facilities.

Samuel Kaplan, M.D.

The excerpted statements that follow are from the Annual Report for 1967 of the James Jackson Putnam Children's Center:

*The President's Message*

The year 1967 was a notable one in many ways. First, it marked the 25th year of the operation of the Center whose doors first opened in 1943. The growth and development of the Center, like the growth and development of the pre-school youngsters it serves, has not always been easy, but it has been impressive. Initially founded by Dr. Marian Putnam and Mrs. Beata Rank to study and treat the reactions of very young children to the absence of one or both parents called to serve in World War II, the Center has expanded — nurtured by the able leadership of its subsequent directors, Dr. Samuel Kaplan, Dr. David Reiser, and currently Dr. Phillip Gates — into an internationally-known clinic which provides psychiatric services to pre-school children; training to budding child psychiatrists, teachers and social workers who are keenly interested in the emotional problems of the very young; and research into the causes of such problems and into new methods of diagnosis and treatment.

Second, 1967 saw the formal affiliation of the Center with the Boston University Medical Center. For many years, the Putnam Center has had an informal affiliation with the BUMC along with several other child
psychiatric clinics in the area, mainly for training. These associations continue, but now the Putnam and the BUMC will be working more closely to develop a stronger and enriched training program, greater service to the immediate community via the Community Mental Health Center, and a more coordinated research effort. The benefits of this affiliation are already evident, but not all of them will be visible for several years.

While the center can draw much satisfaction from past accomplishments, like any organization worth its salt, it must look ahead and be prepared to adjust to the changing times. Much is happening in the field of child psychiatry, and the Center is now in the midst of determining, through its Long-Range Planning Committee, what its future role will be. The trend is definitely towards what is often referred to as Community Psychiatry, i.e., finding ways to treat more people with a limited number of professional personnel. It is clear that the number of children and families needing psychiatric help even in the area immediately surrounding the Center, far exceeds the Center's ability to provide such services. Our main limitation is not so much space or money, as the sufficiency of trained personnel. There are not enough child psychiatrists today to give the treatment that is needed locally, or for that matter across the nation — and this problem is compounded by the manpower needs of the Vietnam War.

Even if all the graduates of all the medical schools in the United States for the next decade should decide to become child psychiatrists, only a beginning would be made in solving the problem. It follows that one of the most significant contributions the Putnam Center can continue to make is the training of psychiatrists, teachers, and social workers.

Within the walls of the Putnam there is a vast quantity of valuable knowledge which those who play a key role in a child's development would find most helpful and instructive. It is important that this material be disseminated widely to both professional and lay people. The aim of the Center, therefore, is to help more people, at a lower cost, through a combination of increased direct service, the training of more professionals, and a broader research effort.

Daniel Pierce, President

The Director's Report

First to come to mind in highlighting the activities of the past year of the Putnam Center and its staff is the concrete step of a close affiliation with the Boston University Medical Center through its Division of Psychiatry, chaired by Dr. Bernard Bandler, and its department of child psychiatry directed by Dr. Eveoleen Rexford.

This step, completed on October 17, 1967, followed lengthy and careful discussion. The first emphasis was on training, since an institution like the Putnam, specializing as it does in work with quite young children, though often continuing into the early school years, needs affiliation with an institution that provides training for work not only with older children and teenagers but also with adults. This step brings us into closer collaboration with the Thom Clinic which for some years has had an affiliation with the Boston University Medical Center and also with the Boston University/Boston City Hospital Child Guidance Center; it does not vitiate collaboration of the Putnam for the purpose of training with other educational facilities.

Although it was in the area of training that the collaboration with the Medical Center was most fully spelled out in the agreement of affiliation, a general enabling statement concerned with research and service, was also included. To aid in the implementation of the affiliation provided for the creation of a Boston University Child Psychiatry Council, whose present members include Dr. Eveoleen Rexford and Dr. Samuel Kaplan of the department of child psychiatry and three representatives from each of the three participating clinics, the Boston University/Boston City Hospital Clin-
ic, the Thom Clinic, and the Putnam Center. Dr. Barbara Mueller, Dr. Catherine Roff and myself are the present representatives from the Putnam. The Council has three standing committees devoted to service, training and research. We have met as part of the full Council at monthly intervals since November with committee meetings as needed.

One intent of the affiliation was to explore areas of service collaboration, especially in the catchment area designated by the State Department of Mental Health as that to be served by the yet-to-be built Community Mental Health Center: namely, the Roxbury, South End, North Dorchester and Back Bay area. We have anticipated the need for increased service in our immediate area and have continued efforts begun in the past. We are collaborating in the evaluation of children referred from the Head Start classes and have carried out a number of rapid evaluations. This collaboration dates from the summer of 1965 and we expect to further expand this work. We have also been exploring the possibilities of working together with the Head Start project in the Orchard Park Housing complex, which would include selection of mothers and young children for group therapy, and developing methods of training for neighborhood mental health aides.

Phillip H. Gates, M.D.
Acting Director
In Laos with the Dooley Hospital

A report of his summer at Ban Houei Sai on a Smith Kline & French Foreign Fellowship
by Kenneth C. Spengler, Jr.

In spite of careful preparation and high expectations, our arrival in Vientiane, Laos, on June 16, 1967, was probably the low point in our first two weeks away from the United States. After visiting five cities in a whirlwind 12-day trip through Europe and the Middle East, my wife and I were tired, haggard and completely overwhelmed by the Lao heat and inefficiency.

The plane which carried us from Bangkok to Vientiane was of World War II vintage and crowded with Lao civilians, Russian and Chinese diplomats and American diplomatic mail couriers, all of whom it seemed would go through the tedious customs procedures before us. By a stroke of good luck our passports were processed in the remarkable time of 30 minutes because a Lao minor official mistook us for U.S.A.I.D. (Agency for International Development) V.I.P.s!

We had hoped to meet Tommy Jean Redderson, R.N., the wife of my sponsor, on our arrival at the airport, but because of an inevitable communications mixup we did not run into her until later that day. Thinking we were on our own in Laos, and anxious to begin the serious work of the summer, we made it the first order of business to see how quickly we could get out of Vientiane and up to Ban Houei Sai, the location of the Thomas A. Dooley Hospital.

We headed for the American Embassy and with the generous assistance of Ambassador Sullivan and Dr. Weldon, chief of U.S.A.I.D.'s public health mission, we found ourselves on a small plane headed north to Ban Houei Sai, only three days after our arrival in Vientiane.

The final leg of our journey was perhaps the most pleasant, flying some 220 miles northwest into the mountainous country that comprises most of the Kingdom of Laos. We flew over seemingly endless stretches of lush green terrain, broken only by an occasional river and small mountain top village set among fields of rice and poppies.

Ban Houei Sai

Ban Houei Sai, the largest town in the most northern and western province of Laos, is situated on the eastern bank of the Mekong River which, in that part of the country, serves as the border between Laos and northern Thailand. The town has a population of about four thousand and serves as the seat of government for Houei Khong province, even though at least two-thirds of the province is under control of Communist forces, the Pathet Lao. In this province the Lao people actually comprise a very small portion — from 10-15% — of the population; the rest being made up of...
numerous hill tribes such as the Meo, Yao, Lahu, Misu, Kha and various tribes of Thai stock such as the Black Thai and White Thai, and a small percentage of Chinese who comprise the merchant population of the town. The village is quiet and relatively peaceful, in spite of the constant threat of attack by Pathet Lao and/or North Vietnamese forces.

**The Hospital**

The Thomas A. Dooley Hospital, founded in 1959, has a remarkably picturesque setting, high on a hill overlooking the village. The area served by the hospital includes the entire northern half of Laos plus parts of Thailand (the exact population of this larger area is unknown.) Patients from outlying areas arrive by plane, helicopter, riverboat, or, more often, on foot! Many may have walked or been carried for several days in an effort to get to the hospital. Others last summer walked for 20-24 days out of Communist-controlled territory to come to the Dooley hospital, including one young boy whose eye had been gouged out by a water buffalo.

Monthly inpatient admissions total about 25, but this does not prohibit the use of the ward, porches, and grounds as a sort of “free motel” for families of the sick. Often a patient will be accompanied by his spouse and children, who sleep on a mat under his bed. The family members sometimes light small campfires beside the hospital for cooking rice and vegetables. Although these customs make it almost impossible to keep the ward and grounds clean, the doctor soon learns that he can’t fight it and probably shouldn’t try.

Facilities at the hospital site include a fairly well-equipped operating room, without general anesthesia; a laboratory equipped to do the common blood, urine and stool examinations; and x-ray equipment. A kerosene-fed generator provides power for the x-ray facilities, a few hours of electric light in the evening, and refrigeration for food and some medicines. As the kerosene is donated and not available in great quantities, we tried to use it sparingly. Water is heated and food cooked over charcoal. Even the clothes iron is warmed by hot charcoal. Since there is no pump to work the well, we had no running water. Rainwater was collected in barrels and river water was hauled from the Mekong every day.

**Our House**

In spite of these conditions, life was pleasant in our ramshackle French colonial house next to the hospital. This house had been
Severe coughing subjects the delicate tissues of the lung to repeated trauma. While it is not certain that trauma propagates alveolar wall destruction, the histories given by patients strongly suggest that this is so. Coughing itself is an irritant and thus tends to lead to more coughing. Too few people realize that coughing is not a harmless privilege, but is in fact a source of irritation and damage to the bronchi and lungs.

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Side Effects: May include mild constipation, nausea, facial prunus, or drowsiness.

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of loss of appetite and a rundown feeling and would persist in going into lengthy detail until they were given vitamins. Even the Lao soldiers from the fort nearby would come in complaining of weakness, and fears that they could not be brave and strong, unless they had vitamins. Just how prevalent the various vitamin deficiencies were we could not determine, although we saw at least one or two patients a week suffering from night blindness.

The most common diseases treated at the clinic were dysentery, worms, genito-urinary infections (including gonorrhea), pulmonary infections and malaria. Malaria and tuberculosis were very discouraging diseases for us to treat for a number of reasons. First, the patients would not actually be brought to the clinic until the advanced stage of the disease. Malaria was so prevalent that the Lao made a distinction in their language between "normal or ordinary fever" (ki kamada) and the fever associated with malaria (ki san). Many children would come to the clinic with multiple scars over their large dragging spleens. These represented attempts by the village priest-witchdoctor to burn out the evil spirits with hot coals or cigarettes. Second, if we were able to save the patient from the initial acute episode of his disease, he usually required prophylactic chlorquine weekly or, in the case of tuberculosis, a one-two year course of treatment. Very few patients returned to the clinic regularly for drugs. The Thai government had undertaken an ambitious and fairly successful effort to eradicate malaria in that country, but up to the present Lao efforts in this direction have been almost nil.

Besides medical problems, the clinic drew a variety of surgical cases such as abscesses, minor lacerations, fractures and plastic surgery. A few cases of harelip would turn up every month for cosmetic correction, and since iodine-deficient goiter was endemic in our area, women would unsuccessfully plead for surgical correction of their enlarged thyroid. A few gynecological and prenatal cases would also show up every day at the clinic.

The Lao would often make one or two visits before delivery to have us listen for the fetal heartbeat and to receive iron and vitamins. However, the women would never come in for a delivery. Delivery was treated casually, an ordinary occurrence; I don't think the Lao ever considered that we might be of assistance.

Some diseases which are common in the U.S. seem to be very rare or absent in that area of the world. During my stay I did not see any patient with a myocardial infarction or even with angina. In the year Dr. Redderson was at the hospital, he saw only one myocardial infarction and that was in a local Chinese merchant. The decidedly slow-paced life of the Lao perhaps is what protects them from atherosclerosis. Bleeding or perforated ulcers are also quite rare in Laos, although we frequently saw patients with gastritis. After sampling the extremely spicy Lao-Thai food, one could only wonder why more natives don't develop gastritis!

The one case of diabetes that we saw at the clinic gave probably one of the most interesting histories ever obtained from a diabetic. He had been feeling healthy, although, in retrospect, he admitted to polydypsia and polyuria. However, he noticed that after he urinated on the ground ants would swarm over the spot. He was found to have 4+ glucose in his urine.

The hospital also had two leprosy patients who were followed regularly. Both patients fortunately had mild forms of the disease and appeared to be responding favorably to the sulfa medication.

The Hospital Day

The typical hospital day began with a cacophony of sounds under our window. We could always count on being awakened by the shrill scream of the Lao roosters or by the packs of stray dogs which roamed throughout the village. (A Lao would not dream of impounding or killing one of these dogs because of the chance that the dog might be an ancestor reincarnated.) After catching up on the world news via the Voice of
America, the workday would begin with brief ward rounds. Following rounds, the rest of the morning was spent in the clinic. The standard procedure was for Dr. Redderson or me to examine the patient with one of the Lao medics or nurses serving as interpreter. Seven or eight different languages might be spoken in the clinic in the course of a morning and occasionally when a hill tribesman did not speak Lao, we would need one interpreter to translate from the patient's language into Lao and then another interpreter to translate from Lao to English. After the decision was made as to the form of treatment, the medications were distributed with the proper instructions by one of the Lao nurses. When it was appropriate, Sai, our chief medic, would speak to the patient about preventive measures such as boiling the drinking water, proper bathing, not spitting on the floor, etc. During the morning clinic, certain required procedures, such as chest taps, x-rays, I and D's of abscesses, would be delayed until after clinic was over in the early afternoon.

The afternoon was spent in a variety of ways. The main allotment of time was devoted to the hospital patients. This time was used for changing special dressings, applying casts, minor surgery and other special procedures. Quite often we would get a wireless call from the airstrip or boat landing that patients had arrived and were wait-to be picked up by the Dooley jeep (one of the half dozen motor vehicles in the entire town).

Many afternoons we received war casualties — more and more as the summer progressed — which would be air-evacuated from skirmish areas into a helicopter landing pad about 200 yards from the hospital. With the arrival of battle casualties, either military or civilian, all other activities were suspended. Victims usually arrived in groups of 3-7, so all available hands were busy cleaning, debriding and dressing the wounds as well as administering medications and setting up beds, often in the aisles or on the porch.

On the rare afternoon that wasn't completely taken up attending to the needs of the patients, there were many other hospital needs that required attention. There seemed to be endless maintenance problems. In the course of the summer, the jeep broke down several times, and the boathouse tore away from its mooring and started to drift downriver. In August, an enormous shipment of hospital and household supplies arrived overland by truck in Chiengkhong, Thailand,
across the river from Ban Houei Sai. It took all the ingenuity and brawn we could muster to get those crates down the very steep and muddy banks of the Mekong, loaded into the boats, across the river and a little way upstream, then up the banks on the other side, into our jeep, and on to the Dooley garage. Not one package was lost in the river!

"The weather and the fighting"

Despite a relative calmness of life in Ban Houei Sai it never seemed to lack excitement. Main activities and interest seemed to center around the weather and the fighting. The rainy season began shortly after our arrival and a lot of attention was focused on how fast the river rose each day. The previous year the huge Mekong had overflowed its banks and flooded most of northern Thailand and the western section of Laos. On several occasions the river rose 3-4 feet overnight, which caused some anxiety, but then we would usually get a few rainless days and the river would recede. The rains also brought another problem — mud. The roads, which during the dry season were hardly fit even for jeep travel, became treacherous during the rains. Driving the jeep down the hill from the hospital into the village at times felt like skiing, and a slide off the road meant knocking down some unfortunate family's home.

"The opium war"

Ban Houei Sai was reputedly the packing and staging area for the Lao opium trade. Opium is the largest cash crop in Laos and second only to gold in importance to the Lao economy. The opium traffic in that area of Laos and in bordering areas of Thailand and Burma was controlled by two groups of Chinese bandits. By midsummer these two groups had had a "falling out" and began fighting. For a while there were rumors that they were headed toward Ban Houei Sai, and wounded Chinese showed up at the hospital for treatment. Whatever danger there might have been had passed within a couple of weeks, and we later learned that the battle had taken place many miles up river along the Burmese border.

In connection with the opium war, as it was called, and with Pathet Lao infiltration, we heard many tales of atrocity; and in fact, encountered some pretty horrible scenes. We had been in Houei Sai for only a few days when a group of Lao soldiers came to the hospital with the head of a P.L. in a cotton sack. It was recommended that the house and hospital be protected at night, and we were furnished with weapons. My wife and I passed the remainder of our time at Ban Houei Sai with an AK rifle under the bed.

The People

In spite of those occasional grisly occurrences, the Lao in general proved to be a gentle and kind people. The hospital staff and the villagers we knew through my wife's English classes were very generous to us. When our departure time drew near, a Lao ceremony, known as a Baci, was held in our honor. The village elder hosted the ceremony, which was held in our common room on floor mats. One of the main attractions in a Baci, besides the rice wine, is a magnificent display of fragrant flowers arranged in a large silver bowl on a pedestal. Many toasts were drunk to happiness, riches, many wives and children, safe journeys, etc. The elder, or priest, began the wishes of good luck and success by tying strings around my wrists and murmuring incantations to Buddha. The medics and students presented small gifts to us, and everyone encouraged us to leave the strings on our wrists until they rotted or wore out, else all their prayers would be for nought.

By the first week of September we were able to get space on a charter flight and, rather reluctantly, departed for Vientiane en route to Hong Kong. My experience with the Smith, Kline & French Foreign Fellowship Program has been an unforgettable one, and I look forward to the time when I can return to Laos as a practicing physician.

Kenneth C. Spengler, Jr. will graduate from the School of Medicine in June, 1969.
a threat to privacy?

Editor's Note: During the summer a lively and searching correspondence, debating one of the most controversial problems of our times, took place between the Medical Foundation, Inc. and Dr. Charles K. Nagy, Director of our BUMC Computer Center, in which other officials of the Center, including Nelson F. Evans, U.H. administrator, also had a share. The sequence is self-explanatory.

Except from letter from Dr. John N. Noble of the Medical Foundation to Dr. Nagy:

"Several months have passed since the inception of the Health Information System Feasibility Study. We have learned a good deal about record-keeping and data processing in health and related agencies in metropolitan Boston. Your cooperation and interest have made our progress to date possible.

"As we enter the final stages of study, several salient issues remain to be explored. We feel new information services, organizations, and systems will be most usefully and economically designed if potential users and contributors are represented in the design and planning stages. We wish, therefore, to represent as accurately as possible your ideas and preferences as potential users and con-
Did your sister have an illegitimate baby, when she was 15?

As Dr. Herbert M. Teager, Head of our Biomedical Engineering Section put it: "It is too vague to be against it, it makes one nervous... It should be very clearly spelled out. Those, who provide information, should know in advance, who controls that information and also, what kind of service they can get in return for their contribution."

In our telephone conversation a few weeks ago you pointed out that your organization, The Medical Foundation, Inc., works on this problem on the basis of a sub-contract with the Joint Center of Urban Studies of MIT. The Foundation is conducting an impartial investigation of the problem; it approached ten hospitals and in its report it wants to reflect the opinions of those ten prospective users and contributors.

I think that the attitude of your organization is correct and I am glad to give you an opinion on the matter in the hope that this will help the Medical Foundation to move in the right direction.

Undoubtedly, we are living in an era of computerization. Indeed, computers are playing an ever-increasing role in our lives. Many branches of the U.S. economy are computerized already. The manufacturing processes in our industrial plants are automated; the accounting, payroll, economic planning and forecasting in most of our business establishments are being done by computers; the transportation system, especially air traffic, is controlled to a large extent by electronic brains; our whole defense system and the tremendous accomplishments in science and especially in space technology would not be possible without modern electronic computers.

Computers can store large amounts of information with fast, almost instantaneous retrieval capabilities. No wonder that pressures are mounting in our society to create regional — or even national — data banks which would help fight crime, promote medical care, improve our educational system and serve many other worthwhile purposes in the interest of all society.

It is clear, however, that a large part of the information stored in data banks may be the kind that a person would not want generally known about himself or his family. For that reason the public as well as computer and legal experts are becoming acutely aware of the dangers inherent to such information systems.

Computer magazines (Datamation, Com-
Were you ever arrested?

puterworld, Data Processing Magazine, etc.) are constantly publishing articles concerned with the inalienable rights of the human individual and even the popular press often contains warnings that data banks are a threat to privacy. Jack Star, senior editor of LOOK, wrote an article on this subject in the June 25th, 1968, issue of his magazine ("The Computer Data Bank: Will It Kill Your Freedom"). His introductory lines are worth quoting: "Did your sister have an illegitimate baby when she was 15? Did you fail math in junior high? Are you divorced or living in a common-law relationship? Do you pay your bills promptly? Are you willing to talk to salesmen? Have you been treated for a venereal disease? Are you visiting a psychiatrist? Were you ever arrested? Have you taken an airplane trip in the past 90 days; with whom; and in which hotels did you stay?

"The answers to these intimate questions and hundreds more like them have always been available to a persistent investigator with enough time and money to sift the paper trail we leave behind in file cabinets, around the country. But now, for the first time, in this age of computers, it is becoming possible for any snooper to get such information quickly and cheaply, without leaving his office chair."

During the past two years there have been attempts to introduce legislation in Congress for the creation of a National Data Bank which would combine the data processing installations of many Federal agencies into one huge data center. Because of strong criticisms coming from both inside and out-side of Congress, these attempts failed and it can be hoped that if this plan is ever carried out in the future, proper legislative measures will be taken to insure that national statistics are used to better advantage but without invading privacy. The problem is twofold: on the one hand, improper information should not be available for storage in data banks; on the other hand, proper safeguards must be established against usage of the information for illegitimate purposes or by unauthorized persons.

As Phil Hirsch points out in his article "The FCC Utility Inquiry" (Datamation, April 1968 issue) the Justice Department suggested a number of legal controls that might be considered: system licensing and inspection; system certification; licensing of personnel; compulsory insurance and/or bonding; criminal sanctions for unauthorized disclosure of information or failure to abide by other rules.

There is no reason why the question of creating regional Data Banks should not be subjected to the same legal, sociological and moral scrutiny that is being applied toward the establishment of a National Data Bank. The examination should be even stricter since the adverse effects of eventual abuse or misuse of information stored in the Data Bank would be felt much stronger locally than on the national level.

The basic guiding principles in establishing regional Data Banks should be as follows:

a) They should serve public or justified private interests; Data Banks should
not be used for immoral or illegitimate purposes;

b) Proper measures should be taken to prevent the entry of improper or false information into the Data Bank;

c) Organizational guarantees and strict supervision should be established in order to prevent any information stored in the Data Bank from being abused or misused;

d) Disciplinary procedures and/or criminal sanctions should safeguard the proper usage of the information stored in the Data Bank;

e) Financial responsibility should be determined and adequate funds should be set up to pay damages to private citizens in case of infringement upon their privacy or constitutional rights.

If any of these principles are violated by the creation of a Data Bank, such a bank must not be allowed to come into existence. And in case this seems to be an overly strict attitude toward the establishment of Data Banks, I have to point out that the greatest danger in this matter is represented by the ignorance of the uninformed on the one hand and by the complacency of the well-informed experts on the other.

The May issue of the Communications of the ACM published a letter from Russell F. Abbott of Boston which shows this danger with striking clarity:

“Personnel Departments require information from a potential employee about his arrest record (a meaningless and possibly misleading piece of data in light of our ‘innocent until proved guilty’ rather than ‘innocent until arrested’ tradition), about his medical and psychiatric history (information normally accorded great sanctity by our legal system), and of his past record of potentially questionable political associations (i.e. McCarthy — like ‘have you ever been a member of . . .’ questions.)

“But if organizations important in the computer field have so little regard for individual privacy that they include these and similar questions on forms routinely administered to all interviewees, there seems little hope that less experienced information-gathering agencies will have much self-restraint in our fast approaching Big Brother world.”

As far as the practical application of the above listed principles is concerned, I might tell you of our present negotiations with Blue Cross concerning the establishment of the Blue Cross Data Service.

In our Hospital we have a Medical Information System which contains valuable information on all of our patients and which helps our Utilization Committee in performing their functions and also is useful in aiding therapy and medical research.

Blue Cross approached us recently with a plan of creating a Blue Cross Data Service which would use the data provided by participating hospitals and which would generate regularly the reports required by hospital utilization committees. In addition, this service would be able to provide all participating hospitals with the comparative evaluation of their functions.

The idea is good and the planned service would be beneficial to all participating hospitals. Therefore we promised to give our
data to Blue Cross under the condition that proper measures would be taken to protect the rights of the patient.

Blue Cross accepted our conditions (actually they were considering this independently from us) and we will contribute our data to Blue Cross as soon as we get guarantees concerning the fulfillment of our requirement.

The proposals which are being worked out by the Medical Foundation on this subject, are of great importance to every individual. For this reason I have tried to give a clear and definite picture of our opinion in this matter. I hope that it will assist your organization in preserving the rights of the individual which make life worth living.

Sincerely,
Charles K. Nagy, Ph.D.

Memo to Dr. Nagy from Dr. Gerald H. Whipple:
"Thank you very much for sending copies of your correspondence on data banks. Your comments may be considered a minor masterpiece and obviously reflect your long and thoughtful interest in the problem. I could not agree with your conclusions more."

To Dr. Noble from Nelson F. Evans, U. H. Administrator:
"To Dr. Nagy's letter may I add these brief comments which I am certain are not new ideas to you and your associates.

"Service programs are successful if they serve an essential need, well administered and adequately financed. There are many different agencies currently in the process of setting up Data Processing Systems to meet their own needs, i.e. Blue Cross, Massachusetts Hospital Association, State Welfare Departments, Medicare, Medicaid, several individual hospitals in the Boston area, the insurance industry, universities and American Hospital Association. In one way or another each of them influence our operation directly or indirectly.

"It has been a pretty well established rule that "he who pays, calls the tune." Hospitals today depend upon third-party payors for their income, namely, Blue Cross, Private insurance, Medicare and Medicaid with very few private patients. The federal government is increasing its influence in the Hospital field and will continue to do so in greater measure in the future.

"It would seem uneconomical to establish any data collection centers unless they were to serve the major needs of the users. Because 95% of our income now comes from third-party payors, increasing direction and control over our operations is bound to follow. Today, the main focus of concern in health care is on more efficient delivery of service, quality of care, and the rising cost of hospital services. It appears that the content of the Medical Foundation Program is trying to operate on the fringes of the real Medical Care arena. Unless the program gets into the main stream of the hospital industry, its usefulness seems questionable. Already there are many other agencies who have wet their feet in this stream. The water is rising with inflation and with the rising cost of medical care.

"Dr. Nagy had the courtesy of forwarding your letter and his reply before mailing. I have reviewed it with my associates and concur in his major concerns."

Dr. Nagy, who fled his native country, Hungary, as a "wanted" freedom fighter in 1956, is Director of the Medical Center's Computer Center. Returning to Europe for the first time in eleven years during the past summer, just as the invasion of Czechoslovakia was perpetrated, his planned visit of three weeks was cut to one, and he visited friends and family in Budapest and northern Hungary "at his own risk."
CHESTER SCOTT KEEFER

Chester Scott Keefer bears himself with the modesty of the truly noted man, with all that the word implies of reticence and dignity.

Whether he is acknowledging a formal tribute to his "medical statesmanship" at a public gathering of the Medical Center, or sitting in quiet conversation with an interviewer, Dr. Keefer is low-key. But just to see and hear, or be with him is to feel the force behind the absence of "front." And when you also know the achievements of his long career, the apparent contradiction is illuminated. He is gentle; he can be adamant — for his triumphs have sometimes called for toughness. He is compassionate; he can be demanding — and he has needed this balance to give of himself as a loving personal physician and counselor, and an exacting teacher and administrator; as an understanding mentor of young doctors, and as an absolute "dictator" in his wartime role of penicillin investigation and control.

And then, when this dual quality is uppermost in the interviewer's mind, comes Dr. Keefer's sudden smile. Dr. Keefer is slight of build, but his face is round, and his smile gives an almost startling look of youth. It reminds one of the legendary "Keefer stories," and of Dr. William Greer's memories of a certain Parker House party which he hosted for Dr. Keefer on his official retirement five or six years ago: "Back in his Johns Hopkins days, a colleague of Chester was said to have brought some special strains of yeast home from Munich, and they jointly shared a reputation for making the best, most scientifically-brewed beer in the country."
Chester Scott Keefer was born in Altoona, Pennsylvania, and graduated from Bucknell College in Lewisburg with a pre-medical degree in biology and physics. There was no family tradition of medicine; he simply knew that medical scholarship was his goal. Small wonder that he chose Johns Hopkins University, a pioneer in medical education, for his own professional preparation and entered in the year 1918. It was a crucial year for the world as well as for young Chester. He was dressed in the khaki of the World War I doughboy, and included drill among his medical studies. Then when the great influenza pandemic of that year wrote a dreadful postscript to the world conflict, he and his classmates served as orderlies in the University’s Hospitals. He was discharged as a private in 1919 to concentrate on his medical education.

“This was a period of ferment for medical education,” Dr. Keefer recalls. “The Flexner study of 1909 had ushered in an era of great transition, and Johns Hopkins was in the forefront. Their Hospital had in fact been opened before their medical school. As a separate corporation it was close to the University, and the financial connections between the School and the Johns Hopkins Institutions — Medical School, Hospital and University — formed a well-coordinated unit. The first resident training program was at Johns Hopkins. During this transition period, remembered for the great names of Dr. Halsted and Dr. Osler, it became financially possible for the first time for doctors to engage in teaching and research on a full-time basis. Up to then professors had to teach on top of a full regime of patient care. But these drastic changes in medical education cut down greatly on the number of doctors in training: in 1910 there had been between five and six thousand medical graduates; in 1920 there were only 2,500. This condition was responsible for the tremendous shortage of doctors for a long time ahead.”

The young Dr. Keefer spent the four years after his graduation as an Assistant Resident in internal medicine at the big Johns Hopkins Hospital — 800 beds. It was a real “medical center,” Dr. Keefer recalls, although at that time this designation was not official. Then in 1926, he was off across the Atlantic to Munich, Vienna, and a brief stretch in England to study the lay of the land in medical education in Europe — and for a specific purpose. He had been invited to become the first resident physician in medicine at the University of Chicago and the trip was a preparation.

After two years in Chicago, Dr. Keefer embarked on a great adventure, both personal and professional. He set sail for China and the Peiping Union Medical College, and with him went his young bride Jean. Jean Balfour, Canadian by birth, had graduated from McGill University, the Johns Hopkins School of Nursing, and Teachers College, Columbia University.

Established by the Rockefeller Foundation, the institution was the first in China to have a complete school of medicine, including a school of nursing, and all staff were on a full-time basis. “It was a magnificent city, Peking,” Dr. Keefer remembers, “and a wonderful medical facility, beautiful buildings, well-managed. The faculty was completely international — doctors and staff from the United States, Germany, Holland, China. The whole purpose was to enable the Chinese to take over its operation themselves.”

In 1930, Dr. Keefer returned to this country and for the next decade was associated with Harvard and the Thordikne Memorial Laboratory at Boston City Hospital, as Assistant and Associate Professor of Medicine, and for the last two years, Director of the 4th Medical Service.

For us and for the Boston University Medical Center-to-be, the big year was 1939, when Chester Scott Keefer became Director of the Evans, Wade Professor of Medicine, and in the following spring, on the retirement of Dr. Edward Calderwood, Physician-in-Chief of the Massachusetts Memorial Hospitals. It was to be with Dr. Keefer that the School and Hospital finally came together as an operating unit . . . an entity which could
truly support the triple aims of patient care, education and research.

The same years that saw Dr. Keefer begin to lay the groundwork of our Medical Center — for its germinal period was long — saw the United States, after the drastic initiation of Pearl Harbor, become involved in World War II. As Professor of Medicine at Boston University, Dr. Keefer had continued his clinical studies of the use of new chemotherapeutic agents, and he became the choice of our government to assume virtual control of the program for clinical evaluation and distribution of a new group of therapeutic agents, as yet untried — the antibiotics. Dr. Keefer became known in the public mind at that time as "the penicillin Czar." It was a dramatic and pioneering task and one which Dr. Keefer performed despite the anguish of decisions involving who should and should not have this life-saving drug, at the time in desperately short supply.

In the early 1950's Dr. Keefer assumed the role that a colleague, Dr. Baird Hastings, has referred to as "Public M.D. #1." On the establishment of the Department of Health, Education and Welfare, Dr. Keefer was appointed Special Assistant for Medical Affairs to the first Secretary of the Department, Mrs. Oveta Culp Hobby. There followed two years of intensive commuting between Boston and Washington, out of which came Dr. Keefer's precedent-setting contributions to the development of the Public Health Service and the nation's health.

Returning to a full-time concentration on the Evans and the University, Dr. Keefer came one giant step further towards his goal of a closer union for School and Hospital. In 1955, when he assumed leadership of the Medical School, he insisted on the title of "Director and Dean," for only in this way did he feel the proper emphasis could be placed on the relationship of School and Hospital.

In 1959, Dr. Keefer became the Director of the Medical Center, and in 1961, he received the highest academic honor of the University when he became University Professor of Medicine. For the past several years he has continued his significant work of evaluating the famous "six year plan" of medical education. It was he who went to the Rockefeller Foundation in 1959 to get the funds to make possible this curriculum study, a development of the so-called "combined program," leading to a degree in six years.

Dr. Keefer's beloved wife and companion of 40 years died in 1967. She, too, had served the Hospital with devotion as an active member of the Aid Association for many years. Dr. Keefer's daughter, Ishbel, is Mrs. Carl B. Lyle, Jr. and Chapel Hill is almost commuting distance these days. Dr. Lyle is Associate Professor of Medicine at the University of North Carolina School of Medicine, and Director of Medicine at the Dorothea Dix Hospital in Raleigh. There are two grandchildren, Scotty, and young Ishbel, better known as Mei Mei, or "little sister."

As a leisure time activity Dr. Keefer admits to loving medical history and the browsing among old books that adds fuel to the fire of his interest. He is a knowing follower of sports from the spectator view and is reported by those who knew him at Johns Hopkins to have been an uncanny expert on "the horses." He takes pleasure in the skill and coordination of today's athletes, especially the current heroes of baseball. Dr. Keefer is at home in the world of music and has played the violin as a member of a string quartet.

An admirer of Dr. Keefer's has said, "Just mention Chester Keefer's name and you can cash a check in China." And now, once more the China Medical Board who have sought his counsel on many other occasions have asked Dr. Keefer to assess the present state of medical education in East Asia. He departs New York for Honolulu and Tokyo on September 23, continuing to Hong Kong, Bangkok, Kuala Lumpur and Singapore in October and returning to Boston by way of Taiwan and Hong Kong.

Fortunately for the Boston University Medical Center and the world of medical education, "Emeritus" is only a word to Chester Keefer and not a way of life.

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The Medical Center could borrow a slogan from industry “And The Beat Goes On,” for our campus “rocks” to the sound of construction in every block.

Block # 1. The Medical School opened its doors this year in its new — and still incompletely — Instructional Building, and Students are currently in class under jury-rigged conditions. Despite strikes and shortages of certain materials school was able to open on September 9. Classes are being conducted in all areas of the building and in many cases with workmen under foot.

Floors 1 through 5, which house most of the Medical School Classroom areas, and the Gross Anatomy on the 10th level are humming with educational activities. The contractor concentrated on getting these particular floors ready so that school could open on time, but several months are still required to complete all phases of construction for our new Instructional Building. Our indefatigable faculty has gone to work under these trying conditions in order to have school start in the new building, and to avoid a disrupting move during the school year.
The Medical Research Building, reported in the last issue as about completed, has finally been accepted and the contractor has completed all items for which he was responsible.

Block #2. The installation of the Betatron facility is proceeding on schedule with many of the finishing touches to the building itself now being performed. The installation of the Betatron Machine, which is to be ready by December, is now well into its middle stages of assembly.

Equipment is being installed in the Electric Load Center which will be under the driveway to New Evans. The installation timetable for this new switchgear indicates that the work should be completed by the end of October.

The “beat” that is totally familiar now to the Medical Center Personnel is now sounding on the New Evans site. The installation of piling to support the New Evans Building has been underway since July and is creating considerable noise and disturbance for all occupants in the buildings adjacent to this new hospital facility. Pile driving which started at the end of July will continue probably up to the first of November 1968. The contractor’s schedule calls for three solid months of work to drive all the piles required for this building (over three hundred fifty).

Several related jobs are in simultaneous progress on the New Evans facility. They include subterranean work for the sewers that will service both the Instructional Building and the New Evans Building. Considerable excavation and replacement of sewer lines will be required. All utilities which previously went through the area where the foundation is being created have been removed and temporarily routed around the excavation.

Block #3. The School of Graduate Dentistry is moving quite rapidly and another six weeks should show this building at its full height. The Edison Steam has been extended down East Newton Street and across the street and is ready to enter the building as soon as the contractor requires heat. The present schedule for completion of this building is on or about the first of February, 1969, which means that the building will be enclosed before winter comes and heat will be required.

Steps are being made to install a large tank of liquid oxygen in Block #3 which will temporarily handle the supply for University Hospital. The liquid oxygen will be piped underground to Medical center and across the bridge to the main hospital building where it will go through a distribution system to all areas that are now receiving oxygen from our present manifold system. We are converting from pure gas to a liquid storage system to reduce the number of large oxygen cylinders, now being handled at the rate of fifteen to twenty per day. As renovations are completed piped oxygen is brought to each bedside, and ultimately all beds at University Hospital will have piped oxygen.

The Doctors’ Office Building which encountered a three-month delay because of the iron workers’ strike is once again humming merrily with activities. Finishing touches are being put to the Parking Garage and the Doctors’ Office Building itself is now two floors tall. The curved stairwells at either end are being poured and show signs of being very attractive.

**Rebuilding**

Two new X-Ray Rooms are being prepared on the main floor of the Collamore Memorial Building of University Hospital. The space that these two rooms will occupy was formerly used by the Administrative Staff of the Nursing Department. The rooms will be used for routine x-rays, and between them will be a waiting space, toilet facilities, x-ray development facilities and several dressing rooms. The rooms will be air-conditioned and connected with the overall Communication Systems of the X-Ray Departments.

A warehouse at 17 East Concord Street is also being prepared for hospital use. It is anticipated that much of the storeroom activity now housed in the Robinson basement, as well as dead storage for X-Ray and Medical Records, will find a new home in this facility. The building consists of four floors with approximately 4,000 sq. ft. on each floor, receiving docks, a receiving elevator, and a floor-to-floor conveyor system.

Several laboratory facilities have been enlarged with the clinical labs on the fifth floor of the present Evans Building expanding into the old Hematology Section. Bacteriology on Evans 6 has expanded into what was previously the Evans Library on Evans 6.

“And The Beat Goes On.”
New Doctors Office Building

Dr. Barry Manuel and Dr. David W. Fagell prepare to sign their lease for a suite in the Doctors Office Building, as David T. Rubin, developer of the project for University Hospital, and Dr. Richard Egdahl, chairman of the committee for the new building, look on.

Work on the new Doctors Office Building and Garage, slowed during the summer due to a strike by steel workers, is now moving right ahead and is scheduled to be ready for tenants beginning May 1st of next year, according to David T. Rubin, developer of the project for University Hospital.

Among the first tenants to sign leases for suites in what will be the latest and most modern building in New England for the private practice of medicine are Drs. Louis W. Sullivan, Lilia Talarico, Charles P. Emerson, Jr., David W. Fagell, Barry Manuel, Mark Richman, Charles W. Robertson, Leslie Silverstein, Edward L. Spatz, M. Stuart Strong, Peter Van Orman, and Charles W. Vaughn, Jr.

To be known as "The Doctors Building," the structure now rising at Harrison Avenue between Sharon and East Brookline Streets will originally contain space for approximately 65 doctors and consist of ten stories, with provisions made for the addition of three floors at a later date. The ten original stories will be made up of five office floors rising above a five-level, 250-car garage, with a drug store and coffee shop flanking either side of a dramatically designed story-and-a-half entrance lobby.

Among the many outstanding features of the new building, according to Mr. Rubin, are exterior columns allowing a minimum of interior obstructions and maximum flexibility in suite arrangements. Suite sizes will vary according to the needs of the tenants, and layouts already drawn indicate a wide range of from as little as 400 to as much as 2,500 square feet.

While present commitments indicate a very strong demand for space, Mr. Rubin indicated the hope that all members of the Hospital staff who wish to have offices in the new building will be accommodated.

"Meanwhile Back at the Lab"

It has been rightly said that "He who feeds bread to the starving should not flatter himself that his baking is good."

Those who have responded so enthusiastically to the laboratory data recording system described in an earlier edition of this journal (BUMC SCOPE March, 1967) are reminded that it was proposed as an interim system, hopefully to be replaced at a later date by a more efficient and
sophisticated one. The response is attributable less to the intrinsic merits of the specific proposal than to the basic idea that a serious problem exists in most hospitals and it requires prompt attention. Although there is a significant amount of activity now in progress in the area of laboratory data processing, the systems reported to date all have serious deficiencies which will take time to work out. Since the investments of money and personnel required to produce a functional system are substantial, it behooves hospital personnel to survey and study the situation carefully before making such commitments.

The Clinical Chemistry Laboratories at University Hospital have received a research grant to study a data processing system based on the use of certain I.B.M. equipment in conjunction with the Medical Center computer. We do not delude ourselves into thinking we will have this system working smoothly in a few weeks, or months (or perhaps ever). A progress report is planned for a later edition of SCOPE and at that time a more detailed discussion will be presented.

Meanwhile, back at the lab, the service demands continue to increase. We have graduated to a faster and more efficient Xerox machine and the reporting system continues to suit our immediate needs. Since our last report the system has been installed at the Beth Israel Hospital in Boston and is under consideration at several other hospitals, including the Peter Bent Brigham. We feel that this illustrates once again the fact that practical automated data handling systems are still far enough away to warrant consideration of suitable interim systems.

Joseph Annino

“In Honor of Dr. Relman”
by Chester S. Keefer, M.D.

Editor’s Note: The tribute reprinted here with Dr. Keefer’s permission was delivered on June 27th at an occasion honoring Dr. Relman.

In the life and career of every man there comes a time to change jobs. It was the well-known Bruce Barton who said that when you stopped changing you are through, and I read recently that Dean Arbuckle of Stanford University had a plan to change jobs every ten years, and he has followed it. But it might be added that one should not change jobs merely for the sake of change but to do what you really want to do and not just what you want to do.

The recent elections in France reemphasize their old saying that the more things change the more they remain the same.

So, Dr. Relman, as you are about to change jobs, we gather here tonight, a group of your friends, admirers and colleagues, to extend to you our best wishes for many happy and satisfying years ahead in your new post as Frank Wistar Thomas Professor of Medicine and Chairman of the Department in the oldest medical school in the nation and one that was first established as a department of a college, now known as a University, — the University of Pennsylvania.

We are proud of your achievements in medicine and your contributions to Boston University and the University Hospital. As a teacher, you have never lost sight of your main objective, to advance knowledge and transmit it to students. Over the years, as a teacher, investigator, writer and editor, you have joined a small band of medical teachers who never forgot either the sick patient or the student. You did not join that larger band of younger men who belong to what Osier called the Clinical Prigs.

As a member of the medical clinic, you have served two masters, the teaching institution and the hospital. Entrusted to the clinic are the bodies of the patients and the minds of the students. You have served these two masters and safeguarded both trusts equally and faithfully, and I would like to say that any change which medical teachers of the future propose must abate not one jot or tittle of this solicitude for the sick man which is the first care alike of hospital physician and hospital manager (administrators, superintendents, directors).

We hear much today about the quality of medical care in our hospitals, but I am convinced that nowhere in the world does a hospital patient receive such good care as in our best American hospitals. This is due in part to the excellence of the nursing organization, and to the high level of administrative ability and the rather ample resources of our finest hospitals; and last but not least to the hearty cooperation between medical, nursing and administrative staffs. You have played a significant role in improving the quality of medical care in our institution.

We hear a great deal today about the quality
of medical research, that multimillion-dollar industry in the United States, but not enough about the quality of teaching and education. When medical administrators and faculty members discuss their dissatisfaction with qualities of medical education, they often fall into the trap of thinking that they can improve it by changing the curriculum. Not enough attention is given to the improvement and development of the skills and abilities of excellent, and not just mediocre or good, teachers; and I may add, not enough attention is given to the training of excellent university and medical school administrators, and real leaders in the art of teaching. In this area you have set high standards of excellence as a teacher and you have felt that improvement in education cannot be accomplished by curriculum changes alone.

The relationships between the teachers, the investigators, the administrators in our medical institutions need to be strengthened. In any institution, organization is the body—a dead body, unless animated by and expressing aims and ideals. Ideals can come to fruition only as they are embodied in and realized through sound organization. You have made contributions towards this end.

Dr. Relman, you are going to Philadelphia where, over the last 203 years, the attempt has been made to create an organization which has best expressed, down to the minutest detail, the highest aims of medical education and patient care. Any future forms or any attempt at reform must have their roots in the institutions of yesterday and today, and of our own country. You may study the examples of other lands, and of other schools, and learn from their experiences much to admire, much to avoid; but nothing to be copied blindly without local adaption.

This is neither the time nor the place to talk about the University of Pennsylvania and its medical school, but since the beginning, the University of Pennsylvania has been made famous by the members of its faculty, its teachers, its investigators, its administrators, its doctors, and its students. Now, you will add to that illustrious body and help educate and train the doctors of tomorrow; Boston University’s loss will be University of Pennsylvania’s gain.

Dr. Relman, you have been extremely fortunate in more ways than one, but you have been most fortunate in having Harriet as your wonderful wife, partner and helper; a highly intelligent and charming person, an excellent teacher in her own
right and an expert in her field as you are in yours. You have not gained stature as a physician and teacher alone; you have had a great assist from your wife; a truly great asset. Harriet, I want you to know what we believe, and we salute you.

I want to close with a quotation by the first Professor of Medicine at the University of Pennsylvania, John Morgan.

"Perhaps this medical institution, the first of its kind in America, though small in its beginning, may receive a constant increase of strength, and annually exert new vigour. It may collect a number of young persons, of more than ordinary abilities, and so improve their knowledge as to spread its reputation to distant parts. By sending these abroad duly qualified, or by exciting an emulation amongst men of parts and literature, it may give birth to other useful organizations of similar nature, or occasional rise, by its example, to numerous societies of different kinds, calculated to spread the light of knowledge through the whole American continent, wherever inhabited."

John Morgan, A discourse upon the Institution of Medical Schools in America, Philadelphia, 1765.

This, Dr. Relman, is the code of the first Professor whom you will be succeeding after 200 years, and I know that you will continue to improve upon it.

Our best wishes go with you.

News in Capsule

The distinction of being selected sponsor of the justly-noted lecture series of Boston's Lowell Institute for the season of 1969-70 has recently been conferred upon the Boston University Medical Center. Announcement was made by Ralph Lowell.

A firm commitment for the fall and winter lecture series has been made and plans are already under consideration by a committee headed by Dr. Franz J. Ingelfinger, whose members are Dr. John A. Mannick, Dr. Ruth Levine and Dr. Alan Cohen. Arrangements are in progress for full television coverage.

The BUSM Alumni Class Notes, which for the last two years have appeared in Boston University's tabloid publication Alumni News, will now reach alumni of the School of Medicine in another form, yet to be determined. Robert Fox, Alumni Director, assures the many alumni who look forward to these notes that they will be received in the near future.

A paper entitled "Cholesterol Esterification in Rabbit's Plasma," was presented by Vladimir Stefanovich, Ph.D., Assistant Research Professor of the School of Medicine during the 156th meeting of the American Chemical Society held in Atlantic City September 8-13. The co-author of the work, Dr. Ira Gore, was until recently Chief of Pathology at the Hospital.

Dr. Stefanovich, a native of Yugoslavia, who received his Ph.D. in biochemistry from the University of Belgrade in 1960 joined the staff of the Medical Center in 1965, after coming to this country for post-doctoral work at the Worcester Foundation for Experimental Biology (1960-62), and spending the next two years as Senior Biochemist at the Hoffmann LaRoche Research Division in Nutley, New Jersey.

Dr. Seymour Fisher chaired a symposium on the topic of "Non-Pharmacological Determinants of Human Drug Response" at the late summer
meetings of the American Psychological Association in San Francisco. He also presented a paper on "Professional Responsibility in Drug Research" at another symposium during the meetings which was concerned with "Rights, Risks and Regulations in Human Experimentation."

Hans F. Loeser, a partner in the Boston law firm of Foley, Hoag and Elliot, has been elected a director of the Boston Gas Company. Mr. Loeser is an incorporator of University Hospital and a trustee of the James Jackson Putnam Children's Center of Boston, a new affiliate (see story this issue) of the Boston University Medical Center.

In mid-August University Hospital President Paul F. Hellmuth announced the naming of a new trustee, prominent in the field of electronic engineering: Dr. David I. Kosowsky, President and founder of Damon Engineering, Needham, Massachusetts.

A 1955 graduate of the Massachusetts Institute of Technology, Dr. Kosowsky holds patents for many advances in his field, including selective communication networks, crystal measurement devices, high stability discriminators, and frequency modulation devices. He has authored a number of papers on the synthesis, design and application of crystal filters.

Effective September 1, 1968, Dr. Joseph Copel becomes Chief of Orthopedics, replacing Dr. Kenneth Christophe, now retired.

Effective October 1, Dr. Karoly Balogh becomes Chief of Pathology, replacing Dr. Ira Gore, and coming to us from the Massachusetts Eye and Ear Infirmary.

Effective January 1, 1969, Dr. Robert Feldman becomes Chief of Neurology, replacing Dr. Norman Geschwind, who resigned to become Professor of Neurology of the Harvard Neurological Unit at Boston City Hospital.

Dr. Thomas R. Dawber attended a conference at the University of Illinois August 18-24 on "The Strategy of Educational Program Development," as the representative of the Tri-State Regional Medical Program for the session, in order to report to Dr. Baumgartner and the other coordinators of the Regional Medical Program the results of the meeting which was primarily concerned with the development of postgraduate medical education programs.

In September, after participating in the program of the Tidewater Heart Association symposium on cardiovascular disease held in Norfolk, Virginia, during the first week of the month (presenting a paper on "Arteriosclerotic Heart Disease: Etiologic Factors and Possible Prevention"), Dr. Dawber took off for a return trip to Yugoslavia with Dr. William Zukel of the National Heart Institute. The two doctors will spend the last two weeks of September considering the future course of their epidemiologic study of coronary heart disease in Yugoslavia.

J. Thomas Cathcart of Needham, Chairman of the Personnel Committee of the Medical Center, has been named a member of the Northeastern Regional Manpower Advisory Committee by Secretary of Labor Willard Wirtz. The group is one of seven regional committees set up to advise the Secretaries of Labor and Health, Education and Welfare on manpower problems in its particular area. Mr. Cathcart, executive vice president of the Boston Gas Company, will be a management representative on the committee.

Dr. Lester Dewis, Assistant Dean and Chairman of the Admissions Committee, has been ap-

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pointed to the Active Staff of the Newton-Wellesley Hospital as Chief of Physical Medicine. His new responsibilities at the hospital begin in September.

The Army Commendation Medal "for meritorious service and outstanding devotion to research objectives in the Department of Experimental Surgery, Division of Surgery, Walter Reed Army Institute of Research, Walter Reed Army Medical Center, during the period October 2, 1966, through August 28, 1968" has been awarded to Captain Richard L. Simmons, a 1959 graduate of the Boston University School of Medicine.

During six months of temporary duty in Vietnam, Captain Simmons collected a large amount of data documenting the occurrence and etiology of wet lung syndrome in addition to conducting surveys of hypoxemia, development of respiratory insufficiency, development of coagulation disorders and the pattern of fluid balance in combat casualties. At the Walter Reed Army Institute of Research laboratory he devised a model for the elucidation of the mechanism of septic shock and the role of the central nervous system in the pathogenesis of death in infectious diseases.

Captain Simmons, whose parents Mr. and Mrs. Nathaniel J. Simmons live in Malden, is married to a Malden girl, the former Roberta Grodberg, daughter of Dr. and Mrs. Barton G. Grodberg of Malden. The Simmons and their two small daughters live in Wheaton, Maryland.

Dr. J. D. Keith Palmer, Assistant Professor of Rehabilitation Medicine at the Boston University School of Medicine, has been named to the Architectural Barriers Board by Governor John A. Volpe.

In accordance with the new architectural barriers law in Massachusetts, the Board will set standards seeking to make state buildings (considered those constructed with state, county, or municipal funds) more accessible to the physically handicapped.

To honor the memory of Hannah Hamill, wife of Dr. Robert H. Hamill, Dean of the Marsh Chapel, contributions are being received by the Boston University Cancer Research Fund at University Hospital.

Dr. Vincent J. Patalano, Professor of Medicine at the Boston University School of Medicine took over the post of Chief of Surgery at the Somerville Hospital in July.

After graduation from Harvard, Dr. Patalano received the Master's degree in biochemistry from Boston University, and the M.D. from the Boston University School of Medicine. He served

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"One of New England's leading investment firms"
as chief resident in general surgery at our Massachusetts Memorial Hospitals, later became chief of medical service and hospital commander for the Air Force Medical Service in Japan.

The new Chief of Surgery is a native of Somerville where he lives with his wife and four children and where he maintains an office.

Dean Henry Goldman of the School of Graduate Dentistry received a letter this summer from Dr. Arthur Signorella of Hawthorne, New York, a graduate of the School, from which we excerpt the following paragraph: "Last year in a contest open to all interns and residents of medicine and dentistry sponsored by the Westchester College of Surgeons I submitted my paper on transplantation of teeth. I am proud to inform you that I brought honors to Boston University by winning first prize, and by being the first dentist to ever do so."

Dr. Hytho Pantazelos, Woman Surgeon

Editor’s Note: This story by Betty Curtis with photograph by Calvin Campbell appeared in the Boston Sunday Herald Traveler for July 7, and is reprinted here through the courtesy of the Herald Traveler.

A Boston woman, who has just recently joined the small but select group of women surgeons in the country, performed her first “operation” when she was 14.

Her patient was a cow. It stumbled into some caustic soda on the farm where she grew up. She treated the animal’s burns and it lived.

Soon that little girl, now 34-year-old Dr. Hytho Pantazelos of 10 Emerson Place, will be operating on a very different kind of patient.

Dr. Pantazelos is believed to be the first woman to complete a residency program in surgery at Boston University Medical Center.

All she has to do now is to go through the formality of board exams and then she can set up practice.

But it has taken nine tough years to bring about this happy day — four years at Boston University Medical School; another four years internship at Boston City Hospital and a year’s surgical residency there.

"Boston City Hospital has given me a wonderful opportunity to study all kinds of surgery," said Dr. Pantazelos, whose parents own the Cumberland Farms Dairy Stores in Rhode Island.

"I have helped take out bullets and treat knife wounds . . . assisted at operations on traffic cases . . . all kinds of wounds come your way at the city hospital.

"It has been an experience I couldn’t have got in any other hospital in the world."

At one point in her life only did Dr. Pantazelos decide to forego her desire to be a surgeon and concentrate on medical art instead. This was after she graduated from the University of Rhode Island. She took a three-year course in medical art at the Massachusetts General Hospital and during her studies won second prize in a nationwide medical art contest.

But the old yearnings to be a surgeon returned stronger than ever, so on completing the medical art program she began her medical studies.

Relaxing on her apartment balcony, on her first day in a long time free from being on call, she said: "It’s really an anti-climax. The pressure has been great for so long I can’t get used to it not being there any more."

The apartment where Dr. Pantazelos lives with her husband, Peter, an electronics engineer and executive in charge of corporate planning and
product development at Thermo Electron Engineering Co., Waltham, is easy to run.

"That's the main reason we chose it," she laughed, her clear blue eyes looking out over the Charles River. "I could rush home from the hospital on the MBTA, flick a duster over the place and whip up a meal all in half an hour . . . just before Peter walked in the door . . .

"He's very happy that I have finally made it," she grinned.

Although up to now, surgery has been predominantly a man’s world, Dr. Pantazelos feels women should do well in this branch of medicine. They have more manual dexterity than a man, because they are used to doing more delicate work.

The Development Program—
A Philosophical Look

In November, 1964, we first presented our development program to a group of community and professional leaders at a luncheon in the George Sherman Union of Boston University. At that time the charts, figures and drawings were a distillation of hope and a vision of tomorrow. The hope and vision are becoming reality.

In four short years we have seen the completion of the Research Building and the near completion of the Instructional Building, Library, School of Graduate Dentistry, Radiation Therapy Center and The Doctors Office Building. MediCenter, the extended care facility, was built by others on our campus and linked to our Hospital as an integral part of our operation which will provide needed services of high quality at minimum cost.

The New Evans Building is underway. Plans are drawn for a Health Services Building and the Mental Health Center looms on the horizon. Twenty-seven million dollars of teaching, research and patient care facilities are completed or in progress. Another twenty million dollars in construction is planned for the near future.

Those of us who work in this exciting environment must count ourselves fortunate. We belong to a special band whose job has an end goal of education and service. The tasks of our Medical Center are to educate the physician and his aides, to heal and care for the sick, to seek out the cause of disease, and, having found the cause, contribute to its conquest. Whatever our job, all of us serve in these noble endeavors. Joined with us are trustees, incorporators and friends of our Medical Center. Together we are a task force for humanity.

Institutions such as ours are living organisms, constantly changing to meet different challenges. As concepts of medical care change, as popula-
tions shift, as long as man's mind and thought evolves, so too will our responsibilities change to meet new needs.

The plans of 1964 have already been altered; and a forward look in 1970 may call for entirely new development programs. This is good. For we change or die. Even in Boston, nothing remains the same forever.

There is an obligation on us all to understand, interpret and involve ourselves in the development of our Center — not just in buildings but in programs and people. There is a call for a commitment. This call should be loud and clear to Trustees and Incorporators for their participation in stewardship and financial support. This call should ring out to staff and be answered by proud standards of service and performance.

It matters not one iota that yesterday's vision is changing or that tomorrow's will be different than today's. No one can see so far ahead that he can picture the ultimate medical complex so perfectly designed and operated that there will be no need for dreams. What does matter is that we are part of the growth and the development of something fine and good. It does not matter that we will not complete the work. What does matter is that we participate in it.

Milton Kosen

"Modern Medicine"
Salutes
Dr. Franz J. Ingelfinger

Dr. Franz J. Ingelfinger, after 27 years at the Boston University Medical School and Boston City Hospital, left us last year to become editor of the New England Journal of Medicine. During this past summer, the editors of Modern Medicine selected Dr. Ingelfinger as their "Contemporary" for the July 15 issue and the distinguished subject of their cover story.

A specialist in gastroenterology, Dr. Ingelfinger started his medical career as an instructor in internal medicine at Boston University in 1940 following his graduation from Harvard Medical School. In 1958 he became a full professor and in 1960 he assumed the responsibilities of chief of the Boston University affiliated medical services at Boston City Hospital.

In speaking of contributions he feels he has made, Dr. Ingelfinger, according to the Modern Medicine story, pointed to two: first his training of other gastroenterologists, 15 of whom now head their own units and another 20 or more who hold full-time academic appointments in gastroenterology; and second, his hospital work prior to his New England Journal appointment.

Dr. Franz J. Ingelfinger

Special Improvement Grant For Medical School

On July 18th of this past summer the Department of Health, Education and Welfare's Public Health Service made it known through Drs. Lewis H. Rohrbaugh (B. U. Vice President for Medical Affairs) and Franklin G. Ebaugh, Jr. (Dean of the Medical School) that $1,866,100 had been awarded to the school, as a "Special Improvement Grant," one of 23 awarded to medical schools.

The large grant, which will run for five years, will help the School as it increases the student body 33%, from the present 280 to 384 by 1971-72.

Among the vital improvements aided by this grant: planned faculty expansion; curriculum
changes to include the introduction of new courses in Endocrinology and the Biology of Disease; clerkships in medicine and surgery into the third year and an increase of elective time in the fourth year from the current five months to an eight-month span; the establishment of a Department of Community Medicine; the purchase of urgently needed teaching equipment for our new classroom building, especially in biochemistry, physiology, anatomy, microbiology, pathology and pharmacology; the planned expansion of the new library.

In expressing his appreciation of this generous federal support, Dean Ebaugh said: "Our School was faced with a serious problem of how to fund the many new programs necessary to continue to train its students, attract the new faculty needed to meet the increase in our student body, meet salary commitments and purchase the teaching tools required for our new school facility. We can now go forward to implement these advances."

Summer Fellowship Program

In Summer Fellowship Program

Students of the Summer Fellowship Program in Neurological Sciences came to Boston from medical schools throughout the country. The group is shown here, with Dr. Robert G. Feldman seated in the center, first row.

A summer Fellowship Program in Neurological Sciences for medical students was conducted June 24 through August 24 under the direction of Dr. Robert G. Feldman, Associate Professor in Neurology of the Boston University School of Medicine and Chief of Neurology of the Boston Veterans Administration Hospital. The program was made possible by a grant from the National Institute of Neurological Diseases and Blindness and with the support of the Boston Veterans Administration Hospital.

Applicants from 20 medical schools throughout the country applied for the 15 places in the program. Each selected student was assigned to a staff member for work on a specific research project; all attended teaching conferences and, as clinical clerks, assisted in patient care under the supervision of resident physicians in neurology. Each Summer Fellow received a $600 stipend.

Coming Issue:

Dr. Murray M. Freed will describe the treatment of spinal cord injuries on our Rehabilitation Unit.

Dr. Henry J. Bakst will discuss the new curriculum of the School of Medicine.

Dr. James L. Vanderveen will write on the development of anesthesiology in a university hospital setting.
**Talwin** — brand of pentazocine (as lactate)

**Contraindications:** Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable. Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

**Precautions:** Pregnancy. No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin (brand of pentazocine) should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analogesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

**Adverse Effects:** Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypotension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine
WHATEVER the intensity of the pain
the cause of the pain
the site* of the pain
the duration of the pain
the chronicity of the pain
the age† of the patient

contractions during labor, dermatitis including pruritus, dreams, parasthesia, and dyspnea occurred rarely after administration of Talwin. Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin (brand of pentazocine) has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apneas. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: Adults, Excluding Patients in Labor. Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg.

Patients in Labor. A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Talwin does not require a narcotic prescription or narcotic records. The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally." (WHO Tech. Rep. Ser., no. 343, 1966, p. 6.)

Talwin relieves pain of all types and all degrees—mild, moderate, and severe—in acute and chronic disorders.

86% of medical and of surgical patients obtained excellent to good relief with Talwin 30 mg. administered parenterally.

With Talwin—no narcotic controls

Talwin acts as rapidly as morphine; its duration of action may sometimes be less. Relief of pain with Talwin usually lasts three hours or longer.

Less constipation than with morphine
Less urinary retention than with morphine
Less risk of severe respiratory depression than with morphine
Less nausea than with meperidine
Less vomiting than with meperidine
Less diaphoresis than with meperidine

How Supplied: Ampuls of 1 ml., containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. Boxes of 1, 10, 25, and 100.

Multiple dose vials of 10 ml., each 1 ml. containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. Boxes of 1.

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

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