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McNamara, Owen J.


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Boston University
Sometime next year, television viewers will see a massive documentary about the life and death of cancer patient Joan Robinson at University Hospital.

The question [continued on pg. 13]
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Health Forum

UNIVERSITY HOSPITAL

Health and hospital myths: Let's put some of those Sacred Cows out to pasture

The folklore of health care and hospital operations is replete with myths that, in my opinion, need to be set straight. The following is an attempt to deal with these Sacred Cows in a candid way. I apologize in advance for stepping on some cherished beliefs, and will be mightily pleased if I help to enlighten some of our readers.

**SACRED COW #1: NATIONAL HEALTH INSURANCE IS INEVITABLE AND, IF WE CAN JUST HANG ON UNTIL IT COMES ALONG, ALL OF OUR PROBLEMS WILL BE ENDED.**

If the man on the street (or, for that matter, anyone in the health-care field) feels that national health insurance will end all our problems, then some new understanding is obviously in order. There are only so many health-care dollars to go around, and total national health-care expenditures, as a percentage of the Gross National Product, will probably not exceed the present level of eight per cent under a national health-insurance program. Existing dollars will be redistributed, with more emphasis on primary care and preventive medicine; less emphasis will be placed on specialty care and heroic lifesaving procedures. Most people could be better off under such a system, but the providers of health care certainly won't be: Federal standards and the strings tied to federal dollars will mean more regulation and red tape, and there will probably be less money available than is needed to do the job. Such has been the case with Medicare, Medicaid and every other previous government health program.

**SACRED COW #2: HOSPITALS ARE INEFFECTIVE BECAUSE THEY ARE NONPROFIT AND THUS HAVE NO INCENTIVE FOR EFFICIENCY. THINGS WOULD IMPROVE IF HOSPITAL EMPLOYEES, MANAGERS AND ADMINISTRATORS WERE AS INTELLIGENT AND EFFICIENT AS THEIR COUNTERPARTS IN FOR-PROFIT INDUSTRY.**

In my opinion, this is patently absurd, as I believe most hospital trustees—top people in the for-profit field—will agree. Hospitals today are the most complex institutions devised by man, and I defy any management team or employee group from any other segment of industry to do as well as those who are doing the job now, with the funds that are available. Employee quality and management talent in hospitals has improved dramatically in recent years. There is still room for improvement, to be sure, but we who are doing the job can be proud of our ability to deliver a very complex and critically needed product, 24 hours a day, seven days a week.

**SACRED COW #3: HOSPITALS MAY WELL BECOME REGULATED PUBLIC UTILITIES:**

Correction: They already are! Hospitals are inspected, regulated and generally "controlled" by no less than 30 different governmental agencies, third-party payers, private voluntary agencies and a host of other groups that represent themselves as "guardians of the public interest." This is not sour grapes on my part—I simply state what I perceive as the reality of the situation. Chapter 42 of the General Laws of the Commonwealth, which seeks to control the costs of health care, put the icing on the cake. The health-care system, I am sure, will cope with this situation as it has in the past—but first we must accept the fact that we already are a regulated industry.

**SACRED COW #4: MECHANIZATION AND TECHNOLOGY HAVE REDUCED THE UNIT COST OF HEALTH CARE.**

To the contrary: Technological advances are probably the single most important cause of skyrocketing health-care costs in the past decade. Technology has indeed made it possible for us to deliver better care to more people, but it certainly has not reduced costs.

**SACRED COW #5: MEDICAL EDUCATION IS SELF-SUPPORTING.**

The fact of the matter is that tuition does not cover the full cost of medical education. A significant part of medical education is financed by general tax revenues in the form of research grants that finance faculty members who teach the students.

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Health Forum is a regular feature of Centerscope in which the executive officers of Boston University Medical Center and its members, University Hospital, Boston University School of Medicine and Boston University School of Graduate Dentistry, present their views on matters of current concern. Readers are encouraged to respond to these viewpoints by writing to Letters to the Editor, Centerscope, Boston University Medical Center, 720 Harrison Ave., Boston, MA 02118.
Another important source of faculty salary support is the teaching physicians' patient fees. If the students' tuition is, for instance, $4,500 per year, the actual cost of educating him might be in the vicinity of $10,000 to $15,000 per year or higher. In the postgraduate years of training and finally "producing" a physician through internship and residency, the financial burden is borne by sick people—specifically sick people in teaching hospitals, where stipends for house staff must be paid out of revenues. I am not condemning this practice. Physicians are vital to our society, and we clearly must provide the means for their training. Still, it is important for people to understand how medical education is financed, for it is a major factor in the teaching-hospital cost conundrum.

SACRED COW #6: THE HOSPITAL IS, AND WILL CONTINUE TO BE, THE CENTER OF THE HEALTH-CARE UNIVERSE.

The configuration of the health-care "universe" is being fundamentally altered by the growth of group practice, primary-care centers and neighborhood health centers. The hospital, especially the large urban teaching hospital, no longer can assume its preeminence. To stay at the center of the system, hospitals must more clearly define their relationship with these other important health-care centers and, at the same time, organize their own resources to meet better the health-care needs of the public.

SACRED COW #7: COWS ARE SACRED.

Not so. Cows give milk. Milk is sacred.

John H. Betjemann
Administrator

SCHOOL OF MEDICINE

Health Manpower legislation: An historical perspective

(Dean Sandson testified on this subject on Thursday, Oct. 31, before the U.S. Senate subcommittee on health.)

Deans of medical schools and other institutions that train future health professionals inevitably devote a large amount of their creative working hours to an attempt to predict the federal contribution to their operating budgets. As I write this, important legislation that would either continue or modify federal health-manpower programs is under intense consideration.

Significant federal support of the nation's health-profession schools has not always been a fact of life for deans. Indeed, it only began in the 1960s. As that decade opened, federal support for health manpower totaled only $24 million: $15 million for biomedical research fellowships, $6 million for traineeships for nurses and public-health personnel, and $1 million for support of schools of public health. In an effort to increase the number of physicians, Congress in 1963 enacted the Professions Education Assistance Act, which authorized construction funds for health-profession schools and loans for students of medicine, dentistry and osteopathy. Eligibility for construction funds for the expansion of existing schools was tied to increased enrollments.

Recognition of need

In 1965 Congress for the first time recognized that the health-profession schools served a national need and initiated programs that provided funds for institutional support of a portion of their operational costs. This support was in the form of basic and special improvement grants.

In the late sixties many of the schools were in financial distress. The Health Manpower Act of 1968 provided higher levels of institutional grants, coupled with a requirement for enrollment expansion, with 55 percent of the funds being earmarked for special projects. While the principal purpose of the special projects was to assist the health schools in serious financial difficulties, the Health Manpower Act was primarily an attempt to insure the financial viability of all the health-profession schools. In fiscal 1970, of $54 million allotted for special-projects grants, $38 million was awarded to alleviate financial distress in 109 schools, including 56 of the nation's 102 medical schools and 30 of its 51 dental schools.

In 1971, Congress passed the Comprehensive Health Manpower Training Act, the first attempt to establish a firm and continuing financial base for the health-profession schools. This legislation was influenced by the 1971 Carnegie Commission Report, "Higher Education and the Nation's Health," which recommended that the federal government make a substantial contribution to the basic operating costs of the health-profession schools, to better enable the schools to meet the continued demand for increased health manpower. The Act of 1971, recognizing that the schools needed dependable and continuing federal support of sufficient magnitude to permit realistic planning to meet the health-manpower needs, authorized "capitation grants." Schools received awards ac-
In accordance to a specific formula based on numbers of enrolled and graduated students. As a condition for receiving these awards, schools were required to expand enrollment, maintain nonfederal financial support and submit plans assuring they would conduct at least three of nine "special projects" responsive to national health needs.

A remarkable success

Federal support of the health-profession schools, especially via the capitation approach, has been a remarkable success, helping establish financial stability in most of them. A clear indication of this positive effect has been an abrupt decline in the number of "financial distress" grants awarded following implementation of the 1971 Act: Whereas in fiscal 1971 there were 116 "financial distress" grants (including 60 to medical schools), in 1973 only 15 grants (including only one to a medical school) were awarded.

The effect of federal support on medical-school enrollment has been striking. Between 1960 and 1970, first-year enrollment rose by more than 3,000 students. Then, between 1970 and 1973, such enrollment rose by another 3,000 students. In 1963, 8,772 students entered American medical schools; by 1973, 14,034 entered—an increase of about 70 per cent.

Why should a program that has been so obviously successful be controversial? There are at least three factors playing a role in the controversy. First, although much progress has been made on some manpower problems (e.g., numbers of physicians), others remain largely unsolved (e.g., geographic and specialty maldistribution of physicians). Second, many congressmen are questioning the validity of subsidizing the education of medical students, who very likely will have a large income later. Third, some people in the health-profession schools feel that basic support funds should be given without any attached conditions.

The Comprehensive Health Manpower Training Act of 1971 expired June 30, 1974. Because of these three factors, Congress has been unable to agree upon new legislation. The programs supported under the Act of 1971 were funded during 1974-75 under a continuing resolution, and most are being funded during 1975-76 under a very restrictive continuing resolution that limits expenditures to the 1974-75 level or to that requested in the President's fiscal 1976 budget, whichever is less. As a result, most programs supported under the legislation, including the capitation-grant and special-project-

grant programs, have had a significant reduction in funding for 1975-76. It is likely that 45 per cent less will be spent for these programs in 1975-76 than in 1974-75.

It is essential that a new manpower bill be passed this year. A proper approach to resolving the three areas of controversy needs to be developed. First the major unsolved health manpower problems (especially geographic and specialty maldistribution) should not detract from what has been accomplished; rather, the current bill should be viewed by all concerned as an opportunity to try to make progress in these difficult areas. Second, it should be realized that medical students are not physicians and do not have the financial resources or borrowing capacity of physicians. Medical students should not be treated harshly simply because their future income will be high. Instead, innovative loan programs should be coupled to the solution of geographic and specialty maldistribution. Third, the leaders of the health-profession schools should recall that the federal government in the past has asked that certain conditions be met before health-manpower awards were made. During the past decade the government's principal condition revolved around enrollment increases. The schools responded and many more health professionals were trained. Now, the health-profession schools must work with Congress to try to seek answers to health manpower problems and come up with reasonable, realistic suggestions that can be included in the new bill.

John I. Sandson, M.D.
Dean

SCHOOL OF GRADUATE DENTISTRY

Many concerns involved in shaping a curriculum for dental education

Although dentistry is the health service specifically associated with the maintenance and restoration of health and function of the teeth and tissues of the oral cavity and its associated parts, it is also concerned with the interrelationships of these areas with other parts of the body and with the patient as a whole. Therefore, the dentist must have a broad background in the preclinical and clinical sciences. The burning tongue, the disquamative lesion of the gingiva and oral mucosa, and other lesions of the oral cavity will come under his purview, as well
as the carious tooth or periodontal lesion. It is not sufficient that he be trained in how to place restorations in teeth or construct fixed or removable partial prostheses or full dentures, or even that he know how to care for periodontal diseases. Certainly he must be well grounded in the subjects, but he must be just as carefully trained in the diagnosis and therapy of oral manifestations of systemic disease, infections and tumors. The educational processes involved should be comparable to those of other specialties of medicine.

Combination of talents

However, it should be emphasized also that dentistry as defined entails a wide range of manual therapeutic procedures not encountered in the other medical specialties. It becomes evident that the dentist, therefore, should combine a talent for biology with an inclination for the mechanical.

To achieve a sufficiently broad preparation, it is necessary to include in the present-day dental curriculum experience in medicine, surgery, pathology and oncology.

Such a broad view of the role of dentistry results in a field so wide-ranging that many persons may not wish to attempt to encompass all of it in a career as a general practitioner. Through specialization, the profession has been subdivided into smaller fields so that each may be practiced adequately. Indeed, one may legitimately question whether the public should expect the same person to be capable both of doing a complicated oral surgery procedure and of constructing a fixed partial prosthesis.

In expanding the education of dental students to meet the greatly increased demands the profession makes of its practitioners today, the role of the faculty is critical. It is largely the faculty that determines the qualities it feels should be developed in a potential practitioner, and defines those qualities in terms of the skills, attitudes and abilities the practitioner should possess. No school may expect its students to develop a particular attitude toward their profession unless it is instilled in the student during his training. I believe this matter of attitude to be as essential as technical ability, for it is the obligation of all those concerned with the health services to further the knowledge and understanding of disease and, ultimately, its prevention.

Henry M. Goldman, D.M.D.
Dean

HEALTH CARE MANAGEMENT PROGRAM

The strategy for increasing number of minority persons in health care management

Black isn't beautiful in health administration. It isn't ugly either—it just isn't. More than 10 per cent of America's citizens are black; yet only 1.5 per cent of the membership of the professional organization known as the American College of Hospital Administrators is black. In the Old South, where half of America's black citizens live, aside from governmental and classically Negro institutions, there are only five identifiable chief executives of hospitals who are black; that number should be at least 200.

As we've known it, health management is a career dominated by persons who are white, don't have Spanish surnames, and are male. That domination in the management of the nation's health resources is a social illness, just as a similar domination of the U.S. Congress, the Massachusetts legislature, and our courts is not healthy.

We need to carefully look at such a problem and figure out how it came to be, if we are to adopt a reasonable strategy for correction. It appears there are two very separate and distinct problems: one is race and ethnicity, the other is sex.

While the vast majority of personnel involved in providing health services are female, those who formally identify as pursuing a career in health management are predominantly male. Females compose about 10 per cent of the membership of the American College of Hospital Administrators. A healthy proportion of those persons came into health administration indirectly; their primary identification as a member of a religious sisterhood or of a female-dominated health profession such as nursing.

The problem of underrepresentation of females in health management may be self-curing. Some of the graduate programs in health management are beginning to attract a large number of applications from superbly qualified women. Three programs with large numbers of female applicants are those of the University of California at Berkeley, the Wharton School at the University of Pennsylvania, and the University's School of Management. Without special recruiting and without considering or counting sex in the admission process, our Health Care Management Program found that exactly one half of its entering students in the fall of
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One woman's struggle with terminal cancer—and with a need to relate the last months of her life to other people. The means to this end was a massive public-television film project showing Joan Robinson attempting to cope with her disease at home and at University Hospital. Owen McNamara chronicles the role of University Hospital and its staff in the project. Eric Robinson describes a husband's perspective. Will Lehr focuses on the filming—and the filmmakers.

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Exciting advances in knowledge in their respective fields of linguistic kinesis and child development are the result of pioneering research by William S. Condon, Ph.D. (left) and Louis W. Sander, M.D. (right). Page 25.
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**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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Legal Signs

When is physician liable for negligent acts of a hospital nurse?

by George J. Annas, J.D., M.P.H.

The question of physician liability for actions of nurses and other hospital employees is of growing importance, since the number of paramedical specialists employed by hospitals and the scope of their duties continues to increase. Concurrent with the increase in such personnel is a demand by many that they be afforded sufficient patient responsibility to permit them to care for patients in accordance with their ability and training. Physicians, who are sometimes named in malpractice suits alleging negligence of nurses and other hospital-based paramedical personnel responsible for certain aspects of the care of their patients, should be able to know in advance how courts are likely to treat such claims. In regard to a recent case from Georgia is helpful in illustrating the position.1

The patient involved in this case was receiving postoperative care in a hospital. Following the operation, her physician had prescribed injections of morphine and Vistaril; the injections were to be administered by the nursing staff.

Injection given to patient. On the fifth postoperative day, one such injection was given by a licensed practical nurse. There was evidence that the patient was "considerably overweight," that the medication was to be injected intramuscularly and not subcutaneously, and that proper injection of the plaintiff would have required a one and one-half inch needle. The defendant doctor admitted that he prescribed the medication and that he left no specific instructions as to the size of the needle or the manner in which the injection was to be given. He was not present when the injection was administered.

When the needle was inserted, the plaintiff's buttock "burned like fire." The plaintiff advised the nurse of this sensation and requested that the needle be withdrawn. The nurse, however, continued to insert the needle and administer the injection. While prior injections had relieved the patient's pain, this one caused additional pain that persisted into the following day. Subsequent examination revealed necrotic tissue in the left buttock which had to be surgically removed. The injury was consistent with improper subcutaneous injection, a danger specifically mentioned in the drug's package insert.

Among others, the plaintiff sued the prescribing physician for negligence. The lower court sustained the physician's motion for summary judgment, throwing out the case against him. The plaintiff thereupon appealed to the Georgia Court of Appeals. That court reviewed the facts and noted further that "registered nurses and licensed practical nurses are authorized to administer injections [at the hospital in question]." The court also found that the instructions left by the physician on the order sheet were "clear," and that if the nurse did not understand them she should have either called the physician or consulted her nursing supervisor. The court noted further that the medication in question was routinely administered by nurses without the direct supervision of a physician, and that physicians' orders did not routinely indicate the size of the needle to be used in making an injection. Rather, the customary and routine was for the nurse alone to administer the injection and determine the size of the needle to be used.

Liability rejected. The court had little difficulty finding that the nurse was an employee of the hospital, not of the physician, and accordingly rejected liability based on the doctrine of respondeat superior. In examining other potential bases for liability the court adopted the following language: "Where no unusual features are involved which call for an exercise of medical skill or experience, a doctor may reasonably take for granted that the experienced nurses on the staff of a modern hospital will attend to their ordinary and customary duties without detailed instructions . . . . This being so, the improper administration of the drug by the nurse was not a risk or hazard which the defendant doctor was under a duty to have perceived and guarded against." (Emphasis supplied by the court; citations omitted.)

This statement is consistent with the modern trend to find that physicians are not responsible for the negligent actions of nurses and other trained paramedical personnel acting within the scope of their employment in the hospital setting.2 The only exceptions to this rule appear to be in cases in which the physician himself was negligent in selecting a particular person to perform the act,3 or in which the physician was personally present and was directly supervising the performance of the act.4

Hospital still liable. Of course, the employer of the nurses, i.e., the hospital, remains liable for their negligent acts. As one court has put it: "The test [for hospitals] should be . . . as it is for every other employer. Was the person who committed the negligent injury-producing act one of its employees, and, if he was, was he acting within the scope of his employment?"5

The rule enunciated again is clear and reasonable. Physicians will not be held liable for the negligent actions of hospital employees if no unusual features are involved, the act performed is within the scope of their employment, and the act is customarily performed without direct physician supervision or detailed physician instructions. As nurses and other paramedical personnel increase their legitimate roles in patient care, they and their employers alone will probably be called upon to answer for their negligent acts.

REFERENCES

George J. Annas is director of the Center for Law and Health Sciences, Boston University School of Law. "Legal Signs" is a continuing feature of Centerscope and the Center for Law and Health Sciences.
Kaleidoscope

SGD, Forsyth join to offer special service in preventive care

With the Oct. 8 opening of a preventive dental care clinic, established in conjunction with a Boston school for dental hygienists, the School of Graduate Dentistry, for the first time, offers the community special services in preventive care.

The clinic, organized jointly with Forsyth Dental Center, also provides teaching experience for students in the Masters of Dental Public Health program at SGD's Department of Public Health and Community Dentistry as well as practice in a clinic setting for dental-hygiene students from Forsyth.

Space, faculty, student gains. Clinic space gained with the recently completed four-story addition to the School made the facility possible physically, while the expansion of the number of students in the masters program, from three to 14 — and an increase in faculty — made staffing the clinic feasible.

Dental hygiene students from Forsyth provide services, including oral prophylaxis (cleaning), home-care instruction and topical fluoride treatment, three days per week, under the guidance of the dental-public-health students from SGD. SGD offers clinic-rotation positions for 10 dental-hygiene students in each of Forsyth's three academic terms.

Anthony Jong, D.D.S., M.P.H., chairperson of the Department of Public Health and Community Dentistry, emphasized the benefits of the clinic for people in the community, even though a major goal of the program is to provide training for students in both the BU and the Forsyth clinics. "The services are provided for the community. We're calling all our former clinic patients to let them know about the service."

Jong, who was instrumental in organizing the program, said that having the Forsyth students at the clinic provides the students in the Masters in Dental Public Health program a good opportunity for practice teaching. This arrangement also effectively supplements Forsyth's faculty capacity, he noted. Jong will administer the unit as well as the teaching programs.

Departmental instructor Martha Liggett, R.D.H., M.S., will provide both classroom and clinical instruction to the 11 dental-public-health students who have elected to participate in the teaching program this fall.

Stephanie L. Dort, R.D.H., M.P.H., assistant director of the Masters in Dental Public Health program and assistant professor in the Department of Community Dentistry, will supervise the joint program.

The dental-hygiene students will receive additional instruction and supervision at the clinic from Janet Weber, R.N., R.D.H., M.Ed., a dental-hygiene instructor at Forsyth.

Higher faculty-student ratio. "With this joint program," Jong said, "the Forsyth students will have a higher faculty-student ratio. They will also have the advantage of working in a dental-school setting."

The clinic itself has excellent facilities, according to Stephanie Dort. The large open room contains three modern chairs, providing plenty of space for instructors and students to work together comfortably. One wall of the room is a two-way mirror, which allows supervisors to observe the clinic from a small adjacent office with a minimum of interference.

According to Jong, the clinic provides services not only for the community, but also for the students at the Medical Center. "We're working with Dr. Constance Cormog (director of the Health Service at the Medical Center) to get all the first-year medical and dental students examined. It won't be mandatory, but we do want to encourage them to have an examination."

Study to focus on heart attack, aspirin link

The possibility that a daily dosage of aspirin can reduce individual susceptibility to heart attack is the focus of a BUMC/BCH research team. The nation-wide Aspirin-Myocardial Infarction Study (AMIS), sponsored by the National Heart and Lung Institute, has established an AMIS Clinical Center at the Medical Center and Boston City Hospital. This Clinical Center will be one of 30 located throughout the United States.

Investigation's goals. The primary objectives of the study will be to determine whether the regular administration of small dosages of aspirin (one gram per day, equivalent to three regular five-grain tablets) in patients with previous acute heart attacks will result in a significant reduction either in the frequency of recurrent heart attacks or in total mortality over a three-year period.

Findings from earlier British and American epidemiological studies
showed a need for further investigation. The American study, conducted by researchers at the Medical Center's Boston Collaborative Drug Surveillance Program, found that of 10,052 patients admitted to 24 Boston hospitals, only 3.5 per cent of patients admitted with heart attacks gave histories of regular aspirin use, while 7 per cent of the patients admitted for other diseases said they had been using aspirin regularly.

A major factor in many heart attacks is the formation of blood clots in the coronary arteries that nourish the heart muscle. An early, probably critical, event in the formation of an arterial blood clot is the aggregation, or "clumping," of blood platelets. Platelet aggregation is inhibited by a number of agents, including aspirin. It is believed that such agents may confer some degree of protection against thrombosis in persons with a high risk of such complications.

150 volunteers. Volunteers in the Boston University Medical Center AMIS Clinical Program will be approximately 150 men and women, aged 30 to 70, who have had at least one documented acute heart attack within the last five years and who meet other medical requirements of the study. Volunteers may participate only with the permission of their private physicians.

Principal investigators at the Medical Center AMIS Clinical Program are Dr. William B. Hood Jr., professor of medicine at the School of Medicine, and Dr. Pantel S. Vokonas, assistant professor of medicine. Co-investigators in the study are Dr. Farouk A. Pirzada, assistant professor of medicine; Dr. Thomas J. Ryan, professor of medicine; and Dr. Michael D. Klein, associate professor of medicine.

Series to profile medical leaders

"Leaders in American Medicine," a six-part film and discussion series profiling distinguished physicians, is being held this year at the Francis A. Countway Library of Medicine, 10 Shattuck St., Boston. The films are being shown at 4:30 p.m. in November, February, March, April and May.

The multi-institutional series is being chaired by George E. Gifford, Jr., M.D., an associate professor of socio-medical sciences at the School of Medicine. Gifford is also consultant to the historical collection of the Countway Library and is secretary of the Board of Trustees of the Boston Medical Library.

October session. The first film in the series, shown Oct. 8, featured Helen B. Taussig, M.D., professor of pediatrics, emerita, at Johns Hopkins University. Discussants included Dr. Taussig; Helen Sinclair Pittman, M.D., of the Board of Consultants at Massachusetts General Hospital, and Mary Ellen Avery, M.D., pediatrician-in-chief at Children's Hospital and the Thomas Morgan Rotch Professor of Pediatrics at Harvard Medical School.

The Nov. 12 film will profile Owen H. Wangensteen, M.D., the Regent's Professor of Surgery at the University of Minnesota. Wangensteen and John J. Byrne, M.D., a professor of surgery and socio-medical sciences at Boston University, will discuss the film.

On Feb. 11, a film will feature Charles B. Huggins, M.D., Nobel Laureate (1966) and William D. Odgen Distinguished Service Professor of Surgery at the University of Chicago. Discussing the film will be Huggins and Emil Frei, III, director and physician-in-chief of the Sidney Farber Cancer Center and a professor of medicine at Harvard Medical School.

March film. The fourth film, to be shown March 10, is on Joseph T. Wearn, M.D., the dean of Case Western Reserve University from 1945 to 1960. Wearn and Robert H. Ebert, M.D., the dean of Harvard Medical School, will be present to discuss the film.

George L. Engel, M.D., a professor of medicine and psychiatry at the University of Rochester School of Medicine and Dentistry, is the subject of the April 8 film. Engel will discuss the film with Sanford I. Cohen, M.D., a professor of psychiatry and the chairman of the department at BUMC; and Jack Ewalt, M.D., the associate dean for academic affairs and the Bullard Professor of Psychiatry at Harvard Medical School.

The last film, on May 12, will feature George W. Corner, M.D., the director of the department of embryology at Carnegie Institute from 1940 to 1955 and executive officer of the American Philosophical Society. Corner and John Z. Bowers, M.D., the president of the Josiah Macy, Jr. Foundation, will discuss the film.

Sponsors for the film and discussion series are Boston University School of Medicine, the Benjamin Waterhouse Medical History Society, the Boston Medical Library, Brown University Medical School and Tufts Medical School.

Produced by AOA. The films were produced by Alpha Omega Alpha, a national honorary medical fraternity, and the National Library of Medicine as part of a series, "Leaders in American Medicine, the Autobiographical Memoirs of Eminent Medical Scientists and Teachers." The program is being funded by a grant from the Macy Foundation to the Section on History and Medicine at BUSM.

Refreshments will be served at 4:00 p.m. and the films will begin at 4:30. For more information, contact Gifford at the Countway Library, 354-1415.

BUMC, BCH join for coordinated alcoholism effort

The problem of alcoholism in Boston's inner city will be the target of a unified attack by a number of diverse treatment facilities under a $1.2-million program for comprehensive alcoholism services to be carried out by the Medical Center and its major teaching affiliate, Boston City Hospital.

Announcement of a $1,254,766 grant from the National Institute on Alcohol Abuse and Alcoholism to fund the three-year program was made recently by Leon S. White, Ph.D., Boston's commissioner of health and hospitals, and Richard H. Egdaal, M.D., director of the Medical Center.

The program will tie together several existing alcoholism-treatment facilities, centered mainly in Boston's South End and Roxbury sections, and will add a new short-stay intensive rehabilitation program.

Away from 'the revolving door.' The short-stay program will serve as a way-station between emergency treatment and halfway house or outpatient services, according to Peter H. Knapp, M.D., associate chairman of the Division of Psychiatry at the Medical Center, senior consultant in psychiatry at BCH and the program's chief architect.

"Without such a program," Knapp said, "there is a grave danger of simply perpetuating the old 'revolving
door' system, in which the client went from jail to a detoxification center and back again in a few days — only now they go back onto the street instead of to jail.”

Knapp will serve initially as program director. Sanford I. Cohen, M.D., chairman of the Divisions of Psychiatry at both City Hospital and BUMC, has overall responsibility for the project.

Program funds will provide additional staffing to strengthen existing services and a central administrative staff to coordinate activities of the several agencies. Evaluation, information and transportation services will also be introduced. Some staff members will work at several locations in the program to provide liaison and assure continuity of care for patients moving from one facility to another.

Coordinated services. Alcoholism services to be coordinated under the program include emergency treatment at BCH; detoxification services at the Boston Detoxification Center and at soon-to-be-opened detoxification centers in Mattapan and Roxbury; hospital backup services at BCH; long-term rehabilitation, under BCH direction, at Boston’s Long Island Hospital and Mattapan Chronic Disease Hospital; halfway-house facilities (Open Ear, serving principally the black community in Roxbury; Hope House in the South End, one of the largest halfway houses in the country; and the Salvation Army’s Harbor Light center in the South End); ambulatory and day treatment at BCH, the Dimock Community Health Center — BUMC’s alcoholism service in Roxbury — and the Harbor Light center; and consultation and education services and an outreach program at Dimock and BCH.

Legislation enacted in Massachusetts in July, 1973, abolished the crime of public intoxication and established a program for the treatment and rehabilitation of intoxicated persons and alcoholics. The effect of the legislation, Knapp said, has been to shift the management of the problem drinker from the law-enforcement system to the health-care system.

Two programs merged. The way was paved for a unified alcoholism service for Boston’s inner city in March, 1973, when the two major alcoholism programs at BCH and BUMC were merged.

Linda Amos named dean of Nursing

University President John R. Silber has announced the appointment of Linda K. Amos, interim dean for the past year, as dean of the School of Nursing. She replaces Dr. Irene S. Palmer, who is now dean of the School of Nursing at the University of San Diego.

Dean Amos, formerly an associate professor and assistant dean of baccalaureate affairs, earned a B.S. in nursing and M.S. in medical-surgical nursing from the Ohio State University School of Nursing. Prior to joining the University faculty in 1968, she worked as a staff nurse and taught at Ohio State and the University of New Mexico, where she was chairperson of medical-surgical nursing. In 1970 she was named an Outstanding Educator of America.

Heads legislative group. An active writer and speaker on nursing issues, she was elected chairperson for the Massachusetts Nurses Association Legislative Council this spring.

Anouncing the appointment after a nationwide search, President Silber predicted that under her leadership, “the School of Nursing will move forward with its strong undergraduate component while continuing its emphasis on distinctive graduate nursing education.”

The School of Nursing was named one of the top 10 schools in the nation last year by Change magazine.

SGD graduates pre-doctoral class of 22

The School of Graduate Dentistry recently graduated its first class of pre-doctoral students. During ceremonies in the SGD Auditorium, 22 students, who had been hooded last May at SGD’s post-doctoral graduation program, received their D.M.D. degrees as well as diplomas certifying that they had passed the National Board Examination. A reception for all graduates and their guests followed the ceremonies.

Spencer N. Frankl, D.D.S., associate dean, and Donald F. Mori, D.M.D., director of clinics, conferred the diplomas. They also awarded the senior student prize in prosthetics to Stephen Dulong, D.M.D., for excellent achievement in the field.

Degree a ‘launching pad.’ The principal address was given by Dean Henry M. Goldman, D.M.D., who stressed that the D.M.D. degree is the launching pad for a career in dentistry, and emphasized the need for continuing education.

The School of Graduate Dentistry, established in 1963, was the first graduate dental institution in the United States to provide advanced education and training to dentists in the eight recognized dental specialties. In 1972 the school established a three-year pre-doctoral program which rounded out its curriculum to include the four types of dental education programs — pre-doctoral, postgraduate, continuing education and dental auxiliaries.

Recently the pre-doctoral curriculum has been re-evaluated and the length of the program has been changed from three calendar years to four academic years. The first class of four-year pre-doctoral students will graduate in May, 1977. Members of the graduating class were:

Alice Abu-Samra, Winthrop; Steven Arena, Lynn; Barry Bairounas, Quincy; John Bassett, Boston; Paul J. Brosnan, Arlington; Donna Calsimito, Winthrop, and Stephen Cary, Needham, all of Massachusetts.


John Kacewicz, Cranston, R.I.; Mark Katz, Cambridge; Robert Mandell, Newton Center; Stephen Myers, Watertown, and William O’Donnell, Woburn, all of Massachusetts.

Anthony Pappas, West Newton; Peter A. Payne, North Attleboro; Bruce T. Sallen, Brookline; Charles Terrio, Burlington; Shari Weldon, Roxbury Crossing, and James Zavistoski, Jamaica Plain, all of Massachusetts.
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Joan Robinson

A University Hospital perspective

by Owen J. McNamara

(Continued from Cover)

many will ask, as they follow this unfolding drama, is, Why do you suppose she subjected herself to such intense scrutiny?

Joan Robinson anticipated that reaction. When asked why she was allowing television to stare unblinkingly at her during her life's most agonized moments, she said, "I'm not going to die happily because of this project but I do know that I am going to leave something important behind — something that may help other cancer patients as they confront life with this disease, and their eventual death."

A question for the Hospital. A corollary question about this film documentary may be. Why did University Hospital go along with it, allowing patient Robinson to be treated and to die with television cameras, sound equipment and all those extra people around her bedside?

The Hospital's answer, like Joan's, must focus upon the greater good that will arise from the unusual hurly-burly surrounding her hospitalization. It is true that the camera crew and its equipment from time to time got in the way of doctors and nurses trying to cope with Joan's manifold problems; it is true that several of the staff people were upset by the unorthodox attention Joan's case was getting; it is true also that the presence of the cameras and sound equipment might have altered the behavior of some doctors and nurses, or of Joan herself. It would have been irrational not to have expected all of those things to happen from the outset. Anyone who has ever made a tape recording or posed for a picture knows the feeling of awkwardness that must be overcome.

Nevertheless, that extra pair of eyes brought to Joan's bedside by the camera, and the extra pair of ears represented by the tape recorder, became the eyes and ears of Everyman, a witness to Joan Robinson's struggle. Every person who watches the documentary as it shows Joan and her husband, Eric, and the doctors and nurses attempting to deal with Joan's disease will gain something of great value before the inevitable end comes, and the camera rests over a grave in Southeastern Massachusetts. Virtually every person in the television audience will know someone who has cancer — or will have it himself — before he has lived out his life.

A might be expected in a film of such an unusual nature, the Robinson project produced some moments of unusual tension, even anger, and, at times those close to it experienced self-doubt and despair. Although members of the film crew were just as committed as Hospital personnel to the best possible care for Joan, and were sensitive to her occasional desire for privacy, there were moments when they had to go forward with their work, so that they could tell the story in the way that Joan herself had conceived it. Naturally, this mandate had to be kept foremost in the minds of all who took part. The danger of appearing crass and unfeeling was a risk one had to run in order to do the true and comprehensive job that everyone wanted done. The process of birth has been documented in such a minute fashion, but this project, swinging around life's other terminus, was unique, and unique allowances had to be made, so that the work might be carried out.

Only equipment was "objective." Members of the film crew were not, and could not be, "objective," as a reporter might be in covering a city council hearing. Their cameras and tape recorders remained uninvolved as only machines can, but the people behind them became very close to Joan, and became part of her struggle against a staggering array of cancer-related problems. Fortunately for them, and for Joan and Eric, this bond allowed for some truly relaxed and light moments, and banter that temporarily drove back the shadows and tight feelings.

Owen J. McNamara, managing editor of Centerscope, was the principal member of the Medical Center's Office of Informational Services involved with the film crew developing the documentary on patient Joan Robinson.
The film had developed out of Joan’s friendship with Mary Feldhaus-Weber, the documentary’s director and producer, and the creator of a number of prize-winning films. Mary, in turn, brought New York filmmaker Jon Child into the project as a line producer. Although Joan’s career had centered on writing (at Seventeen magazine, the Boston Herald-Traveler and Women’s Wear Daily), she would not be able to write her story as her illness grew more complicated and robbed her of vital creative energy. Mary and Jon, knowing this film would be one of the most important works of their lives, gathered their crew and began recording Joan’s life with cancer. It was at this same time that Joan, having been told her cancer was incurable, met and married Eric Robinson, a professor at the University of Massachusetts, Boston. Joan was hospitalized at the time, and they were married in the Collamore 5 room that two years later would be the place of her death.

Although they did not begin the Robinson project with the same bond of friendship with Joan that Mary had, the other members of the film crew experienced a growing awareness of Joan as a person who would have a great impact upon their lives. This involvement, added to the technical complications presented by the unprecedented filming task, gave the project a sometimes gargantuan dimension. Staying with Joan, watching her fight against a deepening disease, and trying to tell of that in the most perfect technical terms, became more difficult for the crew as the end grew closer, despite a growing acceptance of the project by those who were caring for Joan at University Hospital.

What some might see as the noble intent of the filmmakers did not always come through as such to some staffers at the Hospital. Every clash, or near-clash, between filmmakers and staff persons arose from a collision between two perceived ideals: the best possible film documentation, and the best possible patient care.

Trouble over sound pickup. One night, for example, the film crew was staying in Joan’s hospital room to tape Joan talking, having learned that their subject was often at her best in conversation about her disease and coming death during the middle-night hours. She seemed more relaxed at that time, and would string out a series of reflections and recollections, sometimes with humor and nostalgia, at other times in flat-voiced acceptance of what lay ahead. On this particular night, the person taking sound was talking to Eric about pain. They heard the moans of another patient, and Eric pointed out that this, too, was a part of the story. He participated in Joan’s pain, and, in a way, in the pain and suffering of others, and this fact was on his mind much of the time. The sound person laid his microphone out the door into the hallway. The cries of that person down the hall were a major part of the Hospital’s nighttime ambiance, especially in light of what Eric had said, and might add immeasurably to that cinematographic perfection the sound person sought. The charge nurse, however, did not see it the same way. Angered at what she saw as the direct invasion of a patient’s right to privacy, she ordered the microphone removed from the hallway, and threatened to end participation in the project.

Fortunately, this collision of interests, by nearly ending the Robinson project, brought things to a head. There was a meeting the next day of the involved doctors, nurses, administration representatives and the film crew. Several ground rules were agreed upon, the principal one being that any time the film crew wanted to film Joan in any location outside of her room, the filming must be approved by the department involved and the way cleared by a representative of the Office of Informational Services. From that point on, the way was considerably smoother, for the film crew kept Informational Services aware of all its plans, so that departmental approval could be obtained in time to allow for the least interruption of patient care and a reasonable amount of preparation by the film crew.

However, no ground rules in the inventive power of man could deal with one persistent feeling: A few Hospi-
tal personnel and several patients expressed amazed anger that anyone could be so insensitive as to film a dying person. They could not understand how the project could be of any use to anyone, and one sensed that they saw the film as revealing an arrogant interest in the sensational and offbeat. One cannot argue with that point of view — it is a deep-seated feeling and cannot be branded "right" or "wrong." Even one who regards the Robinson project as the apex of public-health education because of its universal application to a huge audience of potential cancer patients finds himself silent in the face of that remark: "Oh, Lord. I couldn't watch anything like that. Why do they want to make a film about something so personal and tragic?"

Of course, that very feeling is what the filmmakers seek to deal with. They hope their documentary, simply by being aired across America, will help people confront cancer and recognize the need for intelligent use of medical resources; the other side of that coin, though, is equally important to those who are creating the documentary: death, and the myriad issues it raises.

A fragile balance. There were times during Joan's sickness and the ongoing film/sound activities when it seemed that one slight push might bring the entire project crashing down, just as that last single straw brought down the camel. There was the tense moment when Joan, during one of her 18 University Hospital admissions, was being examined by five residents and interns, while two nurses helped out, and a sound person, a film person and the documentary's director stood by. One of the residents squeezed himself out of the room, stepping over wires and film canisters with a look of disgusted anger on his face. He considered the filming a circus, and threatened to leave the Hospital service because of it.

Joan's doctor, Peter Mozden, M.D., chief of surgical oncology, and Eric Robinson got together with the head of the film crew and a member of the Office of Informational Services. Eric proved to be the key person in negotiating a tighter set of ground rules, with the film crew taking a low profile during the crisis Joan was then undergoing. Mary Feldhaus-Weber commented later that Eric's presence and his "incredibly cooperative" sense for both Joan's care and the film crew's mission saved the day on several occasions.

The incident precipitated by the crowded room and the resident's angered reaction served as a strong reminder to all that restraint was crucially needed; at the same time, it underlined the project's unique nature, and the good that hopefully would derive from it.

The role of Joan. Lying as she did at the epicenter of this drama, Joan seemed to have a larger-than-life role. Although she was the subject of the film, she became a part of the film team at times ("Wait a minute; why not put the mike over here, at the end of the bed?"); while, at other times, she appeared to be playing out what she thought she should be, rather than what she was. But a major part of that was her own complex personality. When, at times, she appeared to be asking more than the usual number of questions, drawing people out for the camera and tape recorder as if she were the film director instead of the subject, she was just being herself. As Dr. Mozden observed, Joan was not only an intelligent woman, but also one who knew so much about her illness that she was almost consulting on the case.

One fact above all others speaks of Joan's involvement in her own documentary: Mozden looks back to her original diagnosis of ovarian cancer and recalls that she was given six months to live. Instead, she lived for nearly two years, with her added days and weeks spinning around the two poles of her illness and the film project. Mozden says, "I really believe that (the project) was a major factor in the long remission she had."

It was not until perhaps a month before her death that Joan became simply the subject of the film, rather than an active shaper of its being: "I am just sick of being sick, and tired of all these tubes and procedures... sick of the whole business... ." In the last few days, she lay in her University Hospital room suffering the final pain and
systemic failure that everyone had known was coming. Although the cameras and tape reels continued to record the story, for her there was no more film, no more taping of conversations about her life and approaching death — there was only the coming to be of the event itself.

The ending begins. The world of Collamore 5 seemed to be centered on Joan now. The nursing staff reached out with all of its ministering talents to make her end comfortable, and off-duty staffers appeared in the long hours of night to see how she was faring. The Hospital, although normally and necessarily preoccupied with the maintenance of professional routine, adjusted cooperatively to the presence of the film crew. As Joan's life ebbed, the delicate balance was maintained between the healing and filming arts.

Throughout Joan's illness, every attempt had been made to insure that she would be no more and no less "special" than any other patient on Collamore 5, or, indeed, in the entire Hospital. Still, she had been special in a way, with all the comings and goings of the film crew, the camera and tape recorder activity and extra people standing in and outside of her room.

Now, as she lay still and dying, those around Joan saw her no longer as the central figure in a film documentary, but as a friend lost to cancer, a very special and warm person whom they could not hold from her mortal end. The film crew drew back as the last minutes ticked by, and sat together in the patient lounge amid the sprawl of film and sound gear, having prayerful and deep thoughts about the woman who had stood in the center of their lives for so many months. The film was completed, but Joan was finished. That was a difficult thing to accept.

The challenge awaits. With filming at an end, the Robinson project crew now turns to the technical challenge of converting hundreds of thousands of feet of film and sound into a tight and telling remembrance of Joan that could be one of the major documentaries of television history. Through this work, they will ensure that their friend Joan will live again, in her very special way. □

I have walked the corridors and wards of University Hospital, day and night, on and off, for these past two years. Most of the security guards now recognize me, though in a few months' time, my face will have been replaced in their minds by that of some other anxious husband or wife, passing into the street at night, bound home for a few hours' sleep before another working day begins. Similarly, there can hardly be a nurse on Collamore 5 who does not know me, at least by sight, and several have become close friends. When we meet we embrace, though I am physically shy by nature, because they have shared my vigil, while I know something of the demands placed upon them, and because we have wept together over my wife's long suffering and, recently, over her death: Jody, Elvie, the Lindas (especially night-nurse Linda), Kathy, Jo, Tricia, Judy, Dorothy, and many others whose names, at this moment of grief, escape me, but whose faces are vivid in my mind's eye. Many times I have helped out with the demanding task of nursing my wife, and I have become, in the course of time, quite a competent practical nurse. The nurse's aides, too, would not, I believe, reject me from their union, because we have often worked side by side.

Primary-care nurse. When I first brought my wife-to-be to Collamore 5, the unit had a system of primary-care nursing, an experimental program that placed each patient on the floor in the special care of one particular nurse. Jody Parmelee was my wife's nurse. She was also my friend, her advocate, our defender against bureaucracy and senseless routine, and her interpreter to other nurses and to doctors, phlebotomists, X-ray technicians and all the other busy people who move in and out of a patient's room. Once the primary-care system was withdrawn, there was never anyone else to do those important jobs for Joan and to do them as well, though I did my best.

I have come to realize that in a big institution like University Hospital, the patient's voice cannot always be heard. Yes, I have heard those voices crying, "Nurse, nurse!" hour after hour, down the corridors of many
wards — cries from patients in delirium, from the spoiled and the cossetted, the fearful and the belligerent; cries that call for divine charity and more than human endurance from the nursing staff. I know that all those cries cannot be answered, at least not immediately, that the burden placed on a staff of whatever dimensions would always be too great. But I would like to make my plea for a return, at least in a cancer-care unit, to the system of primary care, where one nurse is specially responsible for a particular patient, becoming the patient’s advocate in dealings with persons at all levels of the institution. Primary care costs money, but there has always been and still is waste in a hospital that can be avoided.

Expressing feelings honestly. In a note that my wife wrote a few weeks before her death, she expressed her thanks to her doctors and to her nurses. She ended her days in the Hospital on a note of gratitude for tender care, but there were, of course, times when tempers on both sides became frayed. It was my experience that things always got better when patients and nurses and doctors spoke freely to each other about their problems and when they remembered it was dangerous for any of them to believe they could know the complete person through a meeting in a sickroom. I learned from my wife to express my feelings more honestly in the Hospital, to show something of my anger and frustration as well as my gratitude and love. But not all husbands and wives have the good luck to be married to a patient as remarkable for her courage and grace, for her intelligence and persistence, as Joan — and those husbands and wives need support and help, too, as they spend part of their lives in a hospital. Some things do not cost money; they simply require more thought.

The links between the hospital and the home seem to me to need strengthening. We once, for example, received a house-call. Who from? Who else but Job Fuchs, a doctor whom one can meet any moment of the day or night in almost any part of the Hospital. But sometimes at home, we were desperately worried about what action to take, whether to call an ambulance or not, whether to interrupt a doctor’s privacy, how to deal with a nursing problem, whether it was better to die within one’s own four walls or the many impersonal walls of the hospital. My wife was one of the best-informed people about medical resources that I have known, and I am perhaps one of the most obstinate Englishmen that my country has produced — but even we were sometimes defeated. I can look back with some trepidation to moments when the first advice we received from a doctor would have been very inappropriate to have followed; I can look back with admiration to the cool, decisive action and advice we received from others. How can the hospital and the patient in the home communicate with each other clearly and more reliably?

The role of the medical students. I want to tell also about the important role of medical students, who may be only observers when some surgical procedure is being carried out or when some consultation is taking place. If the student looks at the patient, responds to the patient’s fear or sense of humor, has the courage to behave like another adult being in the presence of his no doubt awe-inspiring teacher, he can help the patient more than he knows. If, in some interval that may appear, he can chat in a friendly way, give a hand to clasp, and avoid the habit of pretending that the patient is not afraid and not in need of human contact, he may be more memorable to the patient than the skilled physician or surgeon in charge, and may have contributed something invaluable to the patient’s comfort. I remember the ginger-haired student with whom last February my wife clearly fell in love at first sight because of his kind friendliness, and another to whom she told more of her fears than perhaps she told even me and others who waited upon her words. I would also like to advise all doctors to make sure that they really are expert at inserting IVs into patients with difficult veins instead of merely thinking that they are so.

Last of all, and perhaps most important, I would like to say something about the hospital as a huge living body with a myriad of diversified cells, and the necessity for
the whole organization to be in balance. Patients sometimes know more about the necessity for kitchen staff, launderers, maintenance men, floor-cleaners, porters, or clinical staff then do the doctors. I wish that it were possible to tell all those people — and to reinforce it by constant exchange of ideas — how important they are to the patient’s welfare.

Smiles, services important. When you have nothing to do but lie in bed attached by a dozen tubes to bottles and machines, the sight of a cleaner who really wants to make your room clean and bright, to scrub the floor for the Lord’s sake, to dust off your table and make everything smell sweet, is welcome indeed, and so are a smile and a greeting from the girl with the tray or the guy who pushes your cart.

My dear Joan was a woman who struggled to keep herself clean and sweet despite the many unpleasant aspects of her disease. She needed the help of others to make her environment endurable. It’s no use mending the patient’s plumbing and leaving the bathroom sink plugged up.

I know that Joan and I were not always easy people to deal with, but we had great troubles to combat. We shared them with some of you, and now I, as the survivor, have tried to help resolve them by telling you of my experience in your world and in the world of Joan and myself. After all, we were married in the same room in which Joan died. ■

(Copyright by Eric Robinson)

The filmmakers’ view
by Will Lehr

The Joan Robinson Project began a little more than two years ago. After being visited by two public-television producers, and also considering the idea of writing a book about her experiences, Joan Robinson talked with her friend Mary Feldhaus-Weber about the possibility of making a documentary film of one woman’s struggle with cancer.

As she was to explain it later, Joan was interested in leaving behind some meaningful personal creation. She was also interested in pursuing a project her deteriorating health would permit, something she hoped would be helpful to other people.

100,000 feet of film. Filming began in early December, 1973, with Mary Feldhaus-Weber as producer and director, and Jon Child as line producer. Since then more than 100,000 feet of film, 50 hours of videotape, more than 100 hours of sound recording, and a couple of thousand slides have been shot to record the essence of Joan’s life at home and in the Hospital — her joys, tears, hopes and pain, her good days and bad.

From the beginning, Mary and Jon and the rest of the film crew realized that what they were witnessing was not only Joan’s struggle to come to terms with her cancer, but also the story and struggle of her husband, her relatives and friends, her physicians and surgeons, her nurses both in and out of the Hospital, and of numerous technicians, pathologists, and yes, even filmmakers.

The film has not been easy to make. It was considered an open-ended project, for obvious reasons, but few expected it to continue beyond a year. The project required extensive on-location shooting at the Medical Center as well as at the Robinson home in the Jamaica Plain section of Boston, and occasional shooting throughout the Metropolitan Boston area, each time necessitating the permission and participation of those being filmed with Joan.

Will Lehr, a resident of Brookline, Mass., is associate producer of the Robinson project film crew.
The idea behind such intensive filming was to get as close as possible to the realities of Joan's life by filming events as they happened, unscripted and often unstructured. Toward this end, a rotating three-person crew lived with the Robinsons on a 24-hour basis for seven days last April, videotaping whatever of interest occurred.

The project is being produced for WITF-TV in Hershey, Pa., and is intended for national broadcast on the 250 stations of the Public Broadcasting Service.

**Spin-off medical films.** In addition to the major film portrait of Joan Robinson's struggle with cancer, a number of half-hour films for medical and paramedical audiences are being projected. Subjects to be highlighted are mastectomy issues (e.g., the patient's experience of diagnosis, or the choosing of a prosthesis), the management of tumor pain, stoma problems and techniques, primary-care nursing, and cancer treatment at home.

The exact shape of all these films is not yet known. A detailed editing process — carefully winnowing the encyclopedic amount of visual and audio material down to more manageable lengths — must first take place.

It is the hope and aim of the filmmaking team that the films will increase public awareness about cancer and its treatment, thus facilitating an increase in preventive checkups and early diagnoses.

**One woman's story.** The film portrait designed for public television will convey what it is like to live with a terminal disease. "JOAN ROBINSON: One Woman's Story" will portray the diminishing quality of life available to a cancer patient, and bring the subjects of death and dying to the attention of the American public as subjects worthy of frank and rational exploration, rather than as topics to be repressed or otherwise swept under the rug.

The filmmakers showed some footage of the Joan Robinson experience to a woman whose mother is struggling with cancer. After viewing the footage, the woman spoke of the value the film would have had for her mother and herself: "Had I seen this program when my mother first became ill, I would not have felt as though I had to reinvent the wheel in order to deal, in every way, with the situation."

It is the hope of the producers of "JOAN ROBINSON: One Woman's Story" that the millions of people who see the series — now tentatively scheduled for viewing on the Public Broadcasting Service — will be better able to address the issues that affect us all.

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For further information about this project, please contact Lynda Cutler at MFW Associates, 10 Garden Street, Cambridge, MA 02138. Telephone: 617/661-0779.
SOCIO-MEDICAL SCIENCES:

Growing force in medical education aims for heightened ‘human’ sense

by Lorraine Loviglio

IN the years between 1940 and the late 1960s, the medical profession was the object of enormous public respect and unquestioning patient gratitude, after several decades of unprecedented technological advancement that seemed to promise an end to all the diseases of mankind. Physicians — always highly esteemed — enjoyed a prestige second to that of no other professional group at the time, and perhaps ever in history.

Then the rumblings began. The critics within. Medical students — during the period of campus activism in the late 60s and early 70s — began to call for more social awareness among physicians and to try to fill the gap in their education by inviting their own lecturers on social issues to speak on campus. Even more significant, critics within the profession — many of them eminent physicians — spoke out in increasing numbers, in the pages of medical journals and on speaker’s platforms, to decry the narrowness in training and outlook of the modern physician. John Knowles, M.D., now head of the Rockefeller Foundation and then general director of the Massachusetts General Hospital, publicly referred to doctors as “idiots savants.” The rumblings grew louder.

At the core, human interaction. Norman A. Scotch, Ph.D., chairman of the Department of Socio-Medical Sciences that was created at the School of Medicine two years ago, in part to remedy the very situation that article describes, points out that the physician is caught between conflicting pressures: on the one hand he is required to keep abreast of a constantly growing body of sophisticated technical information; on the other, he is increasingly expected to respond with awareness and sensitivity prepared for the human drama confronting him daily.

Cracks in the pedestal. The rumbling deepened and was revealed to be the sound of large cracks developing in the medical profession’s pedestal.

The blame for this state of affairs hovered only briefly before alighting on medical education. Critics pointed to the inadequacy of present-day medical training for producing physicians with knowledge of the broader human context in which medical practice actually takes place.

“Medical education, after all, is meant to prepare physicians to serve the health needs of human beings,” wrote one such critic in October, 1973, in an article typical of many faulting the narrowness of medical education. “But where in our present-day educational programs, graduate or undergraduate, is there genuinely serious attention devoted to preparing the student to deal with the human elements of medicine? . . . The triumphs of four decades of biomedical research, the unparalleled power of today’s medical technology, fall short of their real potential . . . because modern medical education fails to equip the physician with the psychological knowledge and skills needed for his task.”*

in a number of not-strictly-medical areas for which he has received no training at all.

"When medicine conquered the infectious diseases, the nature of the patient population changed. Now you have a tremendous number of patients with chronic, long-term illness, whose problems are not only medical in the narrow, technical sense, but also psychological and sociological. As a result, doctors who have a tremendous workload are being asked to respond in new kinds of ways for which they have not been trained. By and large, they've only been prepared for the scientific, technical aspects of medicine. As a result, many of them find it difficult to deal with the human problems that arise."

So unusual is it to teach students how to deal with those problems that Scotch believes his may be one of fewer than five such departments in the country. Other groups like it exist, but usually as a subdivision of another department — psychiatry, community medicine, or pediatrics. The trend toward change, however, is unmistakable, and Scotch praises BUSM for being in the vanguard of those responding to what he sees as a very real social need.

What is (are?) socio-medical sciences? Scotch described the department's subject matter as "mainly medical sociology, with some medical anthropology"; it includes as well such areas as the history of medicine, law and medicine, human sexuality, and doctor-patient relations.

The faculty. When he came to BUSM in September, 1973, to establish and head the new department, Scotch brought with him Ralph Hingson, his former doctoral student at Johns Hopkins School of Public Health, where Scotch had been a professor in the department of behavioral sciences. Last year the two men were joined by Judith Swazey and James Sorenson; they began by teaching second-year students, then switched permanently to teaching first-year students. This year the department has been expanded to include two additional half-time people — Janet Pozen, who is working toward her Ph.D. in sociology, and Maureen Giovannini, who recently received her doctorate in anthropology and who also teaches half-time in the University's anthropology department.

The 60-hour course the Socio-Medical Sciences staff teaches is divided into two parts: one half comprising four weekly lectures; the other half consisting of weekly two-hour seminars, of which every student must select two from a list of more than 20. Lectures begin with a look at the social factors affecting the acquisition of disease, and move on to an examination of the process by which the patient decides first, to seek care, and then, what kind of care to seek — whether to go to the emergency room, a private doctor, a pharmacist, or an acupuncturist. Subsequent lectures examine matters as recovery and rehabilitation, the dying patient, and compliance.

"Compliance" refers to whether patients follow the doctor's instructions or not, and Scotch points to this as an example of subjects taught by his department that doctors have not been trained to know how to deal with, sometimes with serious consequences. "A number of studies in the past four or five years have shown not only that more than half the patients don't follow doctor's orders, but further, that most doctors don't

NORMAN A. SCOTCH, Ph.D.

Enthusiastic, humorous, accessible — able to clown with students one moment and lecture sensitively on the dying patient the next — Norman A. Scotch, Ph.D., in many ways embodies the humanist values he seeks to inculcate. His lectures draw on a wide range of sources, from scholarly research to popular novels. He speaks directly, avoiding social-science jargon.

Before coming to BUSM, the new department chairman was a professor of social anthropology at Johns Hopkins, where many of his students were physicians studying for their master's in public health. He has also taught at the University of California Medical School, Harvard University and the Harvard School of Public Health, and was a visiting fellow at the Salk Institute in California.

Alcoholism, the role of stress in disease, and the dying patient are subjects in which he has done extensive research. He was co-principal investigator of a study of life stress and coronary heart disease in collaboration with the Framingham Heart Study, and spent two years in South Africa studying the social and cultural factors affecting hypertension and other diseases among the Zula. He has edited and contributed chapters to two books on the dying patient and on social stress. He is currently at work on two books, one on alcoholism, and the other, a medical sociology textbook for medical students.

His publications are many and feature such disparate titles as "Magic, Sorcery, and Football among the Zula" and "Characteristics of the Self-Sufficient Among the Very Aged."

A man of many interests, who enjoys the play of the intellect over a broad range of subjects, Scotch is sometimes disappointed in the narrow intellectual focus of some medical students. He is generous, on the other hand, in his praise of School of Medicine faculty and administrators with whom he has had dealings, describing them as "excellent guys."
know that their patients are not complying,” Scotch says. “Therefore, when the patient comes back and is not doing better, the doctor thinks the medication is inadequate and switches him to another.” He adds, “What good is all the doctor’s marvelous knowledge, scholarship and erudition, if it doesn’t have any effect on the patient?”

**Life-prolonging decisions.** In his lecture on the dying patient, Scotch treats fascinatingly the complex factors affecting the decision whether to mobilize scarce medical resources to prolong a patient’s life — such factors as the patient’s ability to pay, whether he or she is medically interesting, the perceived social value of the patient (as when extraordinary efforts were made to resuscitate President Kennedy), the patient’s age, and the personal values of the physician.

The course also includes lectures in law and medicine, designed not just to protect the student from future malpractice suits, Scotch emphasizes, but also to provide him or her with some knowledge of patient’s legal rights. “There are a few doctors out there in practice who don’t have the foggiest notion what the legal rights of patients are,” Scotch says. Two lectures and a seminar in law and medicine are given by George Annas, director of the University’s Center for Law and Health Sciences. They have been so popular the department has added a second seminar on the subject.

Other popular subjects — measured by students’ choices of seminars — have been human sexuality (“God, they were angry when they all couldn’t get into it,” Scotch says. “We’ve added more sections this year.”), the dying patient, and primary care — the latter, a seminar given by Ralph Hingson with members of the Boston City Hospital primary-care residency program faculty (Centerscope, Summer, 1975).

**Listening to students.** During the period when the course is being given, department members meet weekly with an advisory group of five elected students and frequently act on their suggestions. As a result of the group’s recommendations, students now take two seminars instead of the one originally offered, and some lecture topics have been dropped while others have been added.

During a lecture last year, a slighting reference to Adelle Davis, the controversial nutritionist, set off an uproar among her student supporters. The result of the furor was the addition of a new lecture and seminar, both given by Judith Swazey, on “Quacks, Fads, and Marginal Healers,” which explores such nonestablishment healing arts as chiropractic, osteopathy, and acupuncture.

Joe Scozzafava, a second-year student, describes the department as “the most responsive to student input to their course. They go to a lot of trouble to find out what students want and then incorporate it into the course,” he says. Perhaps partly because of this responsiveness to their opinions, some students have taken to dropping regularly into the department’s offices on the fourth floor of Building A to chat, gripe, or ask advice.

**An early shock.** But if students appear to have warmed to the new department, they were not always so friendly. When Scotch and Hingson were designing the pioneering new course in the fall of 1973, they were filled, as Scotch

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**JUDITH P. SWAZEY, Ph.D.**

Judith P. Swazey, associate professor in the Department of Socio-Medical Sciences, has a taste for the interdisciplinary. After majoring in zoology and physiology at Wellesley, she received her Ph.D. in the history of science from Harvard in 1966.

Before coming to the School of Medicine in June, 1974, she was a full-time consultant with the MIT Neurosciences Research Program. She has been a consultant to the committee on brain sciences of the National Research Council, a research associate in the Harvard University Program on Technology and Society, a research fellow and lecturer in the History of Science at Harvard, and a biology instructor at Hood College in Frederick, Md.

Swazey’s particular fields of interest are medical ethics and the introduction of new therapeutic developments, and she explains that the two subjects meet in “the whole area of clinical investigation — particularly in research with human subjects, with all the ethical issues that such research poses.” Her books include Human Aspects of Biomedical Innovation (co-edited with two others); The Courage to Fail: A Social View of Organ Transplants and Hemodialysis (with Renee C. Fox); and Chlorpromazine in Psychiatry: A Study of Therapeutic Innovation. A monograph entitled Studies in the Development of Behavior Therapy is scheduled for publication, and she is an editor of The Neurosciences: Paths of Discovery, in press.

“What’s interesting me more and more,” says the soft-spoken Swazey, “is applying what you can learn studying clinical research to more general health-care delivery — problems like informed consent for patients who are in the hospital for routine medical care. How much does the patient have a right to know? How do you allocate resources, ranging from intensive-care units to neighborhood health centers, and not just high technology innovations like artificial kidneys. . . . It gets into areas of health policy and legal issues. It all cuts across (disciplines), which is why I like it. . . . That’s why I trained in biology and the history of science and ended up here.”
tells it, with a high sense of mission. "We thought we were great guys," he says with self-deprecating humor. "We were going to do good. So we sent notices to the students asking for their input. And lo and behold, about 15 students got together and marched in to see Vince Lanzoni [then associate dean for curriculum]. They didn't want the course."

To be sure, this was before any teaching had actually begun, so it could hardly be seen as reflecting on the quality of the course. Still, it was a shock to Scotch and Hingson. Two of the students went to the department office, threw the notices at them angrily, and said, in effect, that while they had nothing against the two new faculty members personally, they would rather have six extra weeks in which to complete the pathology course they were struggling with than take some course no one had ever heard of.

"Well, you can imagine how we felt after that," Scotch says. "But we took it as a challenge." Student course evaluations, largely favorable, would seem to indicate the challenge has been met. "The course made me realize there were some important issues in medicine that weren't going to be stressed unless we were tuned in to them," says second-year student Guy Rochman. "For the first time, I saw members of my class discussing, at a deep personal level, how they felt about medicine, instead of just vomiting back a lot of stuff they had memorized. The only pity is, the course was too short," he adds.

There is, however, a wide range of reaction to the course within each class, according to Scotch. "There's one group, about a third of the class, who are already aware of these problems, and don't need us. What we do is provide support, evidence, refinements of their thinking. Another third are very science-oriented and tend to reject this kind of thing. They are very difficult to teach. The most important group is the middle third: they don't know much about it, but are open-minded and willing to examine the issues we raise and to profit by what we bring to them."

"An extraordinary resource." The reaction to Socio-Medical Sciences by other BUSM departments — which might have been excused for being less than warm, in view of the new group's occasional gadfly role — has turned out instead to be enthusiastic. One of the department's areas of expertise being the evaluation of medical programs, it has been nearly swamped with requests for its help in developing other departments' internal evaluation programs or in writing up the evaluation sections of their grant proposals. In the eight-month period from September, 1974, to May, 1975, Scotch's group collaborated with other departments on, or wrote itself, 19 separate proposals.

"The department is an extraordinary resource for the School," according to Dean John I. Sandson, "in that it provides an evaluation skill that was not present here in sufficient depth in the past, and that is especially necessary to many of our current and contemplated research programs."

Among the successful proposals was one for a four-year study of the relationship of drinking to social and psychological problems. The $500,000 study — funded by the National Institute on Alcohol Abuse and Alcoholism,
and currently the department's largest research program — will pose the question, Which comes first, the drinking problem or the life problem? Ralph Hingson points out that most alcoholism research has tended to assume that the problems of drinkers are caused by their drinking. This approach may be too simplistic, he contends. "Alcoholism may instead be a symptom of much more serious underlying problems. It may actually be a very realistic coping mechanism."

**Primary-care program.** Another major activity of the department has been the City Hospital primary-care residency program, in which Socio-Medical Sciences has had a role both in teaching and evaluation. As a member of the primary care faculty, Hingson has been a regular participant in preclinic conferences at which the program's interns discuss their patients. The department's teaching role in the program will expand greatly this year when junior residents in their second year of primary-care training will devote a solid four-month block of time to primary care.

Sorenson and Swazey form the evaluation team for the primary care program, measuring its effectiveness by a combination of methods: direct observation (of both faculty and interns), interviews, questionnaires, and knowledge tests.

Sorenson, who has done considerable research in the area of applied human genetics, also has a leading role in a National Foundation/March of Dimes-funded evaluation (with Scotch and Swazey as co-principal investigators) of the impact and effectiveness of the Foundation's network of genetic counseling centers across the country. In the current first year of the study the research team is looking at genetic counseling at four pilot centers in order to develop valid instruments for a study of a larger nationwide group of centers that will probably follow.

**Lab-clinic flow studied.** In another departmental research project, Swazey is examining a series of case studies illustrating how clinical problems give rise to basic research, as part of an 18-month study for the National Cancer Institute. "Most of the studies of research, and a lot of the political activity in Washington, are based on the premise that research flows only from the laboratory (basic research) to the clinic," Swazey points out. "But when you get into the real world of research, you find that there's no such thing as a one-way flow in either direction. It's back and forth."

These and other departmental research projects are seen as important, but Scotch and his department still place first priority on the teaching of medical students. And while they may pride themselves on being — in Scotch's words — "as hard-nosed scientists as anyone," their message to these students is that any strictly scientific, technological approach to health care — as to any significant human problem — can never be sufficient. As one medical student put it, "When all this training is over, we still have to go out and deal with people — our patients." He and his fellow students, having taken the Socio-Medical Sciences course, can be expected to bring to their practices not only new skills and knowledge, but also a heightened awareness of the importance of the human dimension in medicine that will surely make them better physicians.

RALPH W. HINGSON, Sc.D.

Ralph W. Hingson completed requirements for his Sc.D. degree in behavioral sciences at the Johns Hopkins School of Public Health, under the direction of his advisor, Norman Scotch, in August, 1973, and a month later was at BUSM helping Scotch set up the new Department of Socio-Medical Sciences. As an assistant professor in the department, he leads seminars in primary care; health beliefs, attitudes and communications; and alcohol use and abuse.

"We try to make sure the students won't look at patients as just some sort of disease pathology, but as individuals and as persons working within a social framework," he says of the department's role.

His primary interests are in preventive health behavior, the seeking of medical care once symptoms arise, and compliance after treatment begins. He offers a number of fascinating insights on the subject of compliance, such as the fact that "some patients won't follow a regimen if they feel the doctor holds them in low esteem." A member of the faculty of the Boston City Hospital residency program in primary care, Hingson is also involved in a major departmental study of the relationship of drinking patterns to life problems among self-admitted heavy drinkers in the Greater Boston area.

Gentle and scholarly, Hingson is the son of a physician who developed the jet-injection technique and who runs a medical philanthropic foundation based in Pittsburgh. The young assistant professor has participated in several mass-immunization campaigns conducted by the foundation in Central and South America, studying the way news of immunization programs is spread in rural villages and how receptive villagers are to such programs.

Hingson is collaborating with Scotch on two books, one to be titled *Behavioral Science in Medicine and the Other Social Epidemiology of Alcoholism.* In addition to the Sc.D. from Hopkins, he holds a master's degree in public health from the University of Pittsburgh School of Public Health, and a B.A. from Johns Hopkins.
Exploring rhythms of newborn children leads to insights on 'harmony' and coordination

Dr. Condon with film equipment

WHAT could motivate a person to spend an entire year studying four and a half seconds of film depicting but a few sounds and a few actions? For William S. Condon, Ph.D., associate professor of psychiatry at the School of Medicine, the time spent was crucial to his study of linguistic kinesis — the relationship between body movement and language.

Condon, who holds undergraduate and graduate degrees in philosophy, began probing linguistic kinesis 13 years ago because he thought it was important to study normal and pathological human communications using a nonclinical, empirical focus. The painstaking examination

Dr. Sander with his unique bed

THOSE who have had the joy of caring for a new baby know what can happen in the small hours of the morning. Often, at first, more occurs at that time than during the rest of the 24-hour-day, that is, until the baby's rhythms "tune in" to the differences between day and night. At first, in addition to being awake when the rest of the world is asleep, the newborn baby may be also falling asleep in the midst of eating, or crying from hunger when he should be sleeping.

The fascinating exploration of a newborn's rhythms and of the way the tuning-up process takes place between the baby and its caretaker during the first days of
of that piece of film, frame by frame, was a major empirical attempt to follow the intricacies of human interaction at 1/24th of a second. Condon's intense scrutiny of the film enabled him to make certain generalizations about human interaction, as well as specific observations about the particular instance portrayed.

**Conversation as a ‘dance’**. When two people converse, they probably do not consider themselves participants in a “dance” — but that is exactly what they are, according to Condon. The dance, which Condon calls “interactional synchrony,” arises from the body movements of the listener, corresponding to the structure and rhythm of sound coming from the speaker. Although we are not aware that we are performing this dance and do not perceive it in other persons, Condon asserts, it begins as early as the first day of life.

Dr. Condon films his subjects in front of an oversized grid, ensuring that any body movements will be picked up and measured. The sound and activity are studied using special equipment which Condon hand-turns when playing back the material he has captured. This provides greater control and, consequently, closer analysis, since Condon can “freeze” the action at any point.

Condon's work focuses primarily on abnormal children and their responses to sound. He says he hopes that his work will eventually lead to the establishment of screen programs to test children suspected of having brain dysfunctions. According to the scientist, interactional synchrony can also be a reliable tool in gauging how readily an infant is adapting to his environment.  

**An unusual reaction.** In the 13 years he has been studying interactional synchrony, Condon has observed an unusual occurrence that may have important ramifications: Children exhibiting abnormal behavior appear to respond to the same sound more than once. In other words, he explains, the body movements of such babies correspond to the rhythm of the sound at the time it is being made, and then do so again, up to a full second later. This observation, Condon stresses, does not suppose that a baby actually “hears” the sound twice — only that the reaction appears to be duplicated. Condon has taken his film/sound of such children and achieved a “match” by delaying the sound through film editing techniques and playing it back against the second set of movements. This repeated body movement, he says, appears to be common to children suspected of having a variety of brain-involved illnesses, such as schizophrenia, aphasia and autism.

Although Condon's research in interactional synchrony is mainly directed at brain dysfunction in children, he has also applied his work in other human dimensions, such as cross-cultural or family communications.

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**SANDER**  

the baby's life has absorbed the interest and efforts of the Child Development Unit at the Medical Center for at least the past 12 years. This group of investigators, now directed by Dr. Louis W. Sander, a professor of psychiatry at the School of Medicine, is currently working in the nursery for newborns at Boston City Hospital in collaboration with Dr. Patricia Chappell, clinical instructor at the School of Medicine, research director at Harvard School of Public Health; and Dr. Jeffrey Gould, pediatrician and director of the Department of Newborn Medicine.

**Harmonizing the systems.** “The baby begins life as a composite of semi-independent physiological systems, each with its own rhythm, such as those controlling heartbeat, respiration, brain waves and body movement,” explains Sander. Since these systems affect such activities as waking, sleeping and hunger — and under certain conditions, each has the ability to run on its own time track — they must become harmonized and coordinated within the new baby and in turn, tuned up with the regular periodicities of the world and the people outside the baby.

The challenging research question, posed in 1963 at the beginning of this research, lay in finding ways to discover the delicate mechanisms that make the tuning up possible and unraveling how they worked. Sander says a hunch that the timing and duration of events in the life process was the key. To follow that lead, he needed some observational window on all elapsed time of the entire 24-hour day, not just a sample here and there that was convenient for the researchers, he says. A method that could provide such a window, especially in the life of a mother and her new baby, Sander knew, would be difficult to find.

While working with a device to measure the motor activity of the newborn, which he first had constructed in 1958, Dr. Sander hit upon the idea of using the infant's bassinet itself to monitor the around-the-clock timing of events in the infant. The events could then be matched with the time of occurrence of activities and interventions of the caretaker. It was important that this bassinet be exactly like an ordinary bassinet, both for the mother and for the infant, so that their developing interaction would not be disturbed — no wires on the baby, no special maneuvers by the mother. And so what is now called the “Sander Bed” was developed.

**A continuous record, unattended.** The present model, almost indistinguishable from an ordinary nursery bassinet, provides, unattended, a continuous record on a real-time basis, around the clock and day after day, of seven different states of sleep or wakefulness in the infant — its crying, its respirations, its activity, the time when it is removed from and when it is returned to its bassinet, and the presence of its caretaker. Over the past two years, the research team has accomplished the computer interfacing of the monitor output, so that in a mere 12 minutes of input and data processing time, a printout of detailed results for a 24-hour period can be obtained.

Sander's first findings in the 1960s arose from studies of mother-infant pairs, which he calls dyads, living in different environmental situations. Ten infants spent the
first 10 days of life being cared for in University Hospital's lying-in nursery, while 10 others were looked after individually during those first 10 days by single foster caretakers. The surrogate mother roomed-in with the baby around the clock in a private room on the maternity floor. As a part of their traditional caretaking routine, the nursery babies were much more regimented than their counterparts. Those infants were fed at four-hour intervals on the basis of clock time and often by different nurses. The individually cared-for babies were each fed on demand by a single caretaker and led a much more flexible existence.

**Environment's effect shown.** The studies showed that the babies in the nursery slept and awoke without relation to the nursery's timetable of feeding and caretaking. These infants proved to have the greatest movement and crying at night. On the other hand, babies who had individually roomed-in with a single caretaker, who was attempting to impose no rigid schedule, established their orientation to day and night earlier, demonstrating that the environment helped the baby regulate his needs on a 24-hour basis.

Not only did the tuning-up of sleep and wakefulness develop differently in the two groups, but a number of functions important to the newborn's development also progressed along quite different tracks: the way they looked at faces, handled new experiences, cried and adjusted to feeding.

Sander wrote in a 1972 article in *Psychosomatic Medicine* that the initial separation of mother and newborn infant, practiced so widely in the modern hospital nursery, might not be the ideal setting for the infant's first days of life; in fact it might prove detrimental to the baby's initial adaptation to a 24-hour cycle of rest and activity. Sander considers separation of mother and newborn child, as practiced in most industrialized societies, "unique in natural mammalian infancy" wherein nature has provided its most strongly defended and usually effective means to protect and insure the establishment of these first bonds between the mother and her new offspring. A mother and her baby, during the first days of the child's life, are engaged in "adaptive encounter," a trial and error process, in which both modify themselves to work out a harmonious relationship by their constant communications. These communications are essential to assist the baby in regulating his various activities on a 24-hour basis.

**Caretaker's role crucial.** Because a baby is so sensitive in these early days, the effect of the caretaker is especially important. A mother has a variety of methods available for her part in reciprocal communications. Her "cues" go out to the infant in vocal, tactile and visual form, and they are best received by the child during certain alert periods. In addition, Sander says, it is important that the mother recognize the signals her baby is sending out: A single sound may signal a variety of needs, and the mother must figure out which particular one to respond to. At this point, her sense of how she and the baby are organized in the 24-hour structure of the day plays a crucial role.

Continuous monitoring studies through the use of the Sander Bed have potentially significant benefits beyond a better understanding of the role of the caretaker on a baby's adaptation to life: By setting up a standard of normal behavior through his observations, Sander hopes to recognize more easily abnormal or pathological behavior, and thereby to help at-risk infants — those who have trouble synchronizing the cycles controlled by their systems. "In some cases, it is difficult to tell what state an infant is in," says Sander. "We need a 24-hour picture of the cycling of his various states to help regulate his systems." At present, the Department of Newborn Medicine at Boston City Hospital not only is incorporating these advances in the care it provides, but is also playing a key role in making possible the new insights that are emerging.

In a separate study that seeks to develop more complete information on the long-term effect of infant-caretaker interaction, Sander and a separate group of investigators, headed by Drs. Robert G. Ziegler and Peter J. Musliner, child psychiatrists, are working on the follow-up of young adults who were studied as newborns 20 years ago at Massachusetts Memorial Hospital, which has since become University Hospital. The earlier investigation, based on frequent and detailed observations of 30 children from the time of their birth to the end of their first grade in school, was directed by Dr. Eleanor Pavenstedt, then head of the Department of Child Psychiatry. Sander and the team will study how the style of interactions established in the family at the outset has changed or persisted since that time, and how that style has provided the family context in which the young people have grown up.

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### They helped create Sander Bed

Over the years, the ideas and efforts of a number of engineers and researchers contributed to the development of the Sander Bed, described in the above article. Dr. Sander singles out especially the contributions of Gerald Stechler, Ph.D., now chairman of the Department of Child Psychiatry, BUSM; Richard Burwen, president of Burwen Labs, Lexington, Mass.; Herbert Teager, Sc.D., chief of the Biomedical Engineering Section, BUSM, and lecturer in electrical engineering at Massachusetts Institute of Technology; and Jeffrey Gould, M.D., director of newborn medicine at Boston City Hospital and associate professor of pediatrics, obstetrics and gynecology at BUSM.
Alumni News

Medical, dental first-year classes are profiled

Nearly one half of the School of Medicine's 133 first-year students are interested in pursuing careers in primary care rather than in specialized medical fields, according to an informal poll taken during an orientation program for incoming BUSM students.

Welcoming the new medical students was John I. Sandson, M.D., dean of the School. Dean Sandson stressed to the students that their medical education would involve "learning the art as well as the science of medicine." Quoting from F. W. Peabody's The Care of the Patient, written in 1927, Sandson said, "The secret of the care of the patient is in caring for the patient."

The BUSM statistical picture. Also welcoming this year's class, the largest in the School's history, was Jacob Swartz, M.D., associate dean of admissions and professor of psychiatry. Admitting it was probably no mere coincidence that a psychiatrist had been chosen to be chairman of the admissions board, Schwartz gave the following statistical picture of the first-year medical class:

- 45 students (33 per cent) are members of the University's nationally known Six-Year Program, which combines two years of education in the College of Liberal Arts with four years of medical education at BUSM.
- The 88 four-year students in the freshman class were chosen from more than 4,700 applicants.
- There are 42 women in the class (32 per cent of the total).
- Members of the class come from 20 states and one foreign country.
- Members of the class come from 42 institutions of higher learning.

Welcoming the first four year class of
Boston University predoctoral dental students was Henry M. Goldman, D.M.D., dean of the School of Graduate Dentistry. Dean Goldman referred to the dental-school curriculum allegorically as a four-legged stool, with each leg of equal length and strength. The four legs of the curriculum are basic sciences, medical sciences, dental sciences and clinical practice.

Some statistics on SGD’s incoming class are as follows:
- The class total is 38 students.
- Ten members of the class are women (26 per cent).
- Class members come from 10 states and one foreign country.
- The class membership represents 32 institutions of higher learning.

Fran Perrone

Lanzoni is named dean in New Jersey

Vincent Lanzoni, BUSM ’60, was recently named dean of the College of Medicine and Dentistry of New Jersey — New Jersey Medical School. Lanzoni goes to the New Jersey school from BUSM where he was associate dean for the past five and a half years.

Lanzoni was also an associate professor of medicine and pharmacology at BUSM, an associate professor of pharmacology at BUSGD and a staff physician at Boston City Hospital.

He is the author and co-author of several articles published in scientific journals, and a member of the Massachusetts Medical Society, Alpha Omega Alpha and Sigma Xi. Lanzoni graduated from Tufts University (B.S., cum laude, and Ph.D.).

Boy’s idea brings family to kibbutz, dental care to 150

A School of Graduate Dentistry alumnus and faculty member this summer celebrated the Bar Mitzvah he shared with his 13-year-old son, and, at the same time, brought dental care to more than 150 children in an Israeli kibbutz.

Before his June Bar Mitzvah in Marblehead, Mass., young Frank Sandler decided he wanted to mark the event not with a “huge party with a lot of people he didn’t know,” but rather by taking his family to Israel, said his father, Dr. Eugene S. Sandler, associate professor of pedodontics at SGD.

Dad took vows himself. Although active in his temple, Dr. Sandler had never gone through the formality of a Bar Mitzvah, and decided his son’s own ceremony would be an appropriate time to take the vows himself.

Dr. Sandler, impressed by his son’s timely interest in his religious roots and intrigued at the prospect of such a journey himself, arranged to take his entire family — his wife, Gail, Frank, and the Sandlers’ other son, Stephen, to an Israeli kibbutz for the summer.

He also arranged to donate dental services for the children of the kibbutz during their stay. (A kibbutz is an Israeli communal living unit in which all members work for the good of the community. The children usually live separately from their parents, but maintain a strong familial identity.)

Having completed complex preparations, the Sandlers traveled in mid-July to Kibbutz Yagur, the oldest kibbutz in Israel, for seven weeks.

Upon his return, Dr. Sandler was extremely enthusiastic about the family’s experience. “We want to go back,” he said. “The people in Israel are just great.”

Dr. Sandler worked about 25 hours each week in the small dental clinic in the kibbutz. Because he cannot speak Hebrew, he was provided with a translator at the clinic so that he could communicate with both his patients and the clinic dentist, Dr. Marco. The dental assistant who worked with him had studied English, Sandler said, but she did not use the language. “She was embarrassed,” because she did not believe she was fluent enough in the language to try to converse with the visiting American dentist, Sandler said.

While Dr. Sandler worked in the clinic, Mrs. Sandler shared lifeguarding duties with two residents of Yagur. Although she has taught children at camps in Massachusetts’ North Shore area, she was unable to organize games and competition because of the language barrier. Despite this obvious limitation, she enjoyed providing this service to the kibbutz, Dr. Sandler said.

Seven weeks, 150 youngsters. “In the seven weeks we were there, I completed dental work on 150 out of 200 children under 12 in the kibbutz,” Sandler said. When he left, each was using flouridated toothpaste and had a proper-sized toothbrush. (Sandler said that some of the children had been using brushes that were too large and had far too few bristles.)
Alumni Profile:

A cockpit portrait: The doctor aloft

Accepting life's risks on Great Duck Island

The Gestalt theory of psychology preaches self-discovery and self-utilization. Psychiatrist George Cloutier, M.D., (BUSM '57) who practices Gestalt therapy, took a major step toward his own self-utilization (or "taking and accepting life's risks," as he described it) 14 years ago, when he bought Great Duck Island in Blue Hill Bay, Maine. The island, one and a half miles long and about a half-mile wide, is covered "half with field and half with woods." It lies five miles out to sea, an hour's boat-ride from Northeast Harbor.

Sharing therapy and chores. For the past two years, Cloutier has lived on Great Duck with a dozen patients, sharing not only private and group therapy sessions, but also chores such as chopping wood and milking the goats. "Here, we live together and learn to know one another well, which is quite different from the typical doctor-patient contact of an hour a week in the office," Cloutier said. Other patients come from the mainland every third weekend for a three-day workshop; many others have placed their names on Cloutier's long waiting list of would-be islanders.

Although he was inspired by the same sense of adventure that led him to Alaska for his first year of private practice ("It seemed to be the only place where I could be an over-all doctor and try everything, from pediatrics to surgery"), Cloutier admits that making the transition from city doctor to self-sufficient islander was "a struggle at first." He spent the first 12 years continuing his Massachusetts practice and opening a new one in Bangor, Maine (where he still works in his office every Friday), commuting to Great Duck by boat while he tried to organize his new life.

At the moment, Cloutier and his patients are busy building yurts ("little round wooden buildings, more substantial than tents") for the winter. The doctor is also planning the addition of a self-contained section for adolescents on Great Duck, which he hopes to have completed by next year. Living in a four-room domed house in the middle of his island, communicating with the mainland by a two-way radio and commuting in a new twin-engine airplane, Cloutier has settled into a "very basic" way of life and a very unusual psychiatric practice.

The following profile of Cloutier, by Bill Benson, is reprinted from Down East magazine, June, 1975.

On an early spring morning on Great Duck Island, at the eastern entrance of Blue Hill Bay, the synchronized roar of two powerful airplane engines mingled with the crash of surf and the shrill mews of seagulls. An orange, twin-engine Seabee rumbled down the uneven grass runway and lifted easily skyward. Aloft, Dr. George Cloutier was beginning another day's work in one of the most unusual psychiatric practices in the country.

As Duck Island fell astern of the climbing plane, Dr. George, who has racked up 3,000 hours of flying in 25 years, expertly worked a myriad of dials and gauges on the instrument panel as he headed north to the Bangor International Airport.

At 44, this physician is no stranger to adventure. Before completing medical training he had spent time on a weather station at Thule, Greenland; had run a bulldozer in Labrador; once led an eight-man expedition up Mount McKinley; delivered a baby in the back of a single-engine plane near Fort Yukon, Alaska, and made an emergency landing on the Gaspe Peninsula, first having to hop over a stone wall in a fully loaded airplane.

Search for the perfect island. Once he explored 1,026 Maine and Canadian islands by air, an activity that was later to prove fruitful when he decided to abandon the scramble of city life and practice. To him the "perfect" island was Great Duck. Lying five miles offshore in Long Island Plantation, it is one and a half miles long and about a half-mile wide. Purchase of the property was triggered in part
by boyhood memories of family picnics on history-rich Richmond Island near Cape Elizabeth.

"My life here on Duck is more meaningful, useful, content," Dr. George explains. "I used to make lots of money as a big-city doctor, but I paid a heavy price for it. Now that I've kicked all that, I am a happy man.

When this spring he received invitations to participate in seminar workshops in Amsterdam and Paris, the attraction of his new way of life made travel to Europe unacceptably intrusive.

Once cleared for landing by the Bangor tower, Dr. George glides toward the runway, slowing to eighty knots from a cruising speed of 115 knots. On the ground he taxis to the private airplane area, parks his Seacraft, and gets into his red pickup truck for a ride downtown to his office on Harlow Street.

After seeing his scheduled private patients (Friday is his only office day away from the Island), Dr. George happily returns to Duck Island before darkness falls. The bumpy grass runway has recently acquired flare-pot lighting; the runway he built by himself with a rented bulldozer, but it still needs more work.

**Home in a plastic dome.** His home is a plastic dome erected in the middle of the most exposed field area on the island. Its first installation by friends and patients proved unsuccessful, and the manufacturer's men had to take it apart and start over again. His former island house, a four-room wooden cottage, is now occupied by resident patients. For communication, there is an answering service in Brewer, that supplies a radio-telephone "patch" into the regular telephone system. Occasionally the battery runs down and the offshore community is incommunicado except for the Coast Guard phone at the light station on the southwest point of the island. For fresh water there is a well dug by a farmer over 100 years ago.

Having owned Duck Island for 12 years, Dr. Cloutier now has a productive vegetable garden. Last year he brought in a doe and buck in a 20-foot outboard Seacraft, his original mode of transportation. The deer, of course, immediately zeroed in on the garden, so a big fence had to be built against their further foraging. He also imported a swarm of bees which got loose in the plane's cabin, but fortunately he had the foresight to wear protective gear. In addition to deer there are a Newfoundland dog and a long-haired Siamese cat.

During a winter storm in 1973, Dr. George's boat was sunk, and he and some guests had to be taken to the island in a larger boat from Southwest Harbor. On another occasion he had a narrow escape when his aluminum rowboat overturned in the surf. While he was able to struggle ashore from the icy water, it took longer for his week's supply of groceries to be washed in by the churning Atlantic.

Dr. Cloutier practices Gestalt therapy. "This," he explains, "is one of the newest humanistic trends in mental health treatment. We teach people self-utilization, how to relate better to others, and how to take and accept life's risks. I feel that most people utilize only 10 to 15 per cent of their potential." The doctor studied Gestalt therapy under its greatest living proponent, Dr. James Simkin, in California during 1971 and 1972 before accepting a post with the Counseling Center in Bangor, a grant-supported organization covering the mental-health needs of people in northern and eastern Maine. Now a procession of big-city doctors comes to observe and learn from Dr. Cloutier.

One, Dr. Matthew Lesser of Albuquerque, N.M., and his wife and family have forsaken the busy, more financially profitable life for Dr. George's environmental and professional rewards. Duck Island is fast becoming a mecca for doctors as well as for people who need help.

**Harvard to BUSM.** George Cloutier was born in Portsmouth, N.H., and grew up in a succession of New England towns, including West Minot, Maine. His interest in helping people could well have been stimulated by his mother, a long-time social worker who is now with the Department of Child Welfare in Lewiston. After graduation from Harvard, where his major study was social relations, he went to Boston University School of Medicine, and, upon taking his degree, interned at Bellevue Hospital in New York City. After that came a year of general practice in Fairbanks, Alaska. There, having been a licensed pilot since his freshman year at Harvard, he logged, in a two-place Aerocraft Coupe, some 150 hours of flying of the sort familiar to Alaskan bush pilots.

Dr. Cloutier was married in 1965 to the former Liliejo Hagen, an interior decorator from Oslo, Norway, from whom he is now separated. Their six-year-old son, Eric, frequently visits Great Duck Island. In the early years of their marriage, Dr. Cloutier flew his wife and son in a Cessna Skylane from Boston to Point Barrow, Alaska, making the round trip, somewhat circuitously, in 120 flying hours.

Once, on a movie-making expedition up Mount McKinley with a Walt

![Dr. Cloutier brings his bird home to Great Duck.](image-url)
Disney cameraman, Dr. George and six friends were caught, at 18,000 feet, in a 10-day blizzard, and sought shelter in a crevasse where they played chess on a pocket chessboard for the duration of the storm. (That effectively ended forever Dr. Cloutier's interest in the game.) The men were only four hours away from the summit when they had to turn back.

Dr. George later became founder and co-director for three years of Liberty Street Associates, a psychiatric clinic in Danvers, Mass.; later still he became director of Eastern Middlesex Guidance Center for four years. At Boston's Judge Baker Child Guidance Center, he held a two-year fellowship in psychiatry, and then spent two years at Harvard Psychiatric Service at the Massachusetts Mental Health Center, Roxbury.

Now settled on Duck Island, he plans to build housing for 30 people. But money comes hard. In order to buy his $60,000 airplane, Dr. George had to mortgage the island, whose support takes all his income, for only modest contributions can be expected from the people who live there.

Whale-watching, berry-picking. His plane weighs 3,800 pounds, carries six people, and has a safe fuel range of about five hours. While the doctor loves the plane, he readily admits it has all the aesthetic qualities of an airborne cockroach. Still, its "handiness" cannot be denied. He is probably the only person who ever debarred from a $60,000 machine to go blueberrying off Blue Hill Bay, or who landed on Popham Beach for a quick swim. Frequently he goes whale-watching, island hopping, sightseeing in Canada, or drops into a friendly-looking pond for a picnic.

Dr. George might be poor in money but he is rich in the good and simple things his unconventional way of life provides. Duck Island may sometime have running water and inside plumbing, but such luxuries will be necessarily slow in coming. To the flying doctor of Blue Hill Bay, the interests of humanity take precedence.

A close friend once said that Dr. George had the guts of a bulldog, the soul of a poet, and the mind of a country doctor. And surely, he has to be a country doctor with Duck Island, Maine, for an address; civilian population, 14 or 18, if you count the dog, the cat, and two deer.

**NOTES BUSM**

1929

GERTRUDE J. SMITH writes she is "enjoying retirement from work in India, although I miss the Indian friends there."

1930

NATHAN L. FINEBERG writes "On behalf of the class of 1930 and on the occasion of our 45th reunion year, I wish to congratulate Bob Fox upon receiving a certificate of honorary membership to the Boston University School of Medicine Alumni Association on his retirement as executive secretary. He served well and with devotion for many years. Our best wishes to you, Bob, and your dear wife."

1931

LEONARD B. THOMPSON was given a testimonial dinner, attended by more than 250 people for his 15 years of devoted service to the Naukeag Hospital, Ashburnham, Mass., as medical director. The Naukeag Hospital is a leading institution for the treatment of alcoholism. In addition to many individual gifts, Dr. Thompson was awarded plaques from the governor and the hospital.

1943

FRANCES HAYWARD SMITH retired from the staff of the Lahey Clinic in gastroenterology in 1971 and was a consultant in GI x-ray until 1973. She now divides her time between Pittsfield, Mass., New Hampshire and Boston.

1944

ARTHUR M. PARKER, of Brooklyn, N.Y., passed his re-certifying examination in internal medicine, one of few to be re-certified.

1947

MARVIN J. HOFFMAN's son, William, graduated from Yale University and is now finishing his second year at the University of Rochester School of Medicine. His daughter Holly is a freshman at Cornell; Jennifer, age 10, is at home. Dr. Hoffman's wife, Nancy, is an assistant professor of English literature.

1949

MITCHELL R. ZAVON writes, "Since becoming medical director of the Ethyl Corporation, I haven't seen any of the class, with the exception of the '74 reunion, but I have seen a lot of the world — with a trip around it last fall and a couple of extensive European trips."

1950

IRVING BERKOVITZ - When Schools Care: Creative Use of Groups in Secondary Schools, edited by Dr. Berkovitz, was published by Brunner/Mazel, New York in May, 1975.

1951

RICHARD J. RIHN is the president of the Alameda Contra Costa Medical Association. His daughter Holly is a freshman at Cornell; Jennifer, age 10, is at home. Dr. Hoffman's wife, Nancy, is an assistant professor of English literature.

1952

ALVIN N. EDEN has written a book entitled Growing Up Thin, published by David McKay. It is a pediatrician's approach to...
the prevention and treatment of obesity from infancy through adolescence.

1956

GEORGE J. CHASE is in private practice specializing in medical psychiatry. He is associated with the medical psychiatric hospital, Capistrano By the Sea (Dana Point, Calif.), and is on the staff of Hoag Hospital, Newport Beach, Calif.

1982

FREDERICK M. GAWECKI has been promoted to associate professor in obstetrics and gynecology at Creighton University School of Medicine, Nebraska.

GEORGE WALCOTT has been named president of the Wisconsin Heart Association.

1963

RICHARD K. FORBER is currently an associate professor in the department of ophthalmology at the University of Miami School of Medicine.

ANDREW L. TAYLOR is "still flourishing in the warm, lush hammocks and Everglades of Miami, Fla.," but says he is "waiting each year for cool New Hampshire. Busy here with our children's licensing requirements and planning curriculum for the students."

ALAN J. WABREK and his wife, Carolyn, co-directors of the sexual-therapy program, department of obstetrics and gynecology at Hartford Hospital, were guest speakers at the spring meeting of the Connecticut Association of Marriage and Family Counselors. Dr. Wabrek was also elected to the Board of Directors of that association.

1964

THORNTON C. KLINE, JR. is the chairman of the department of radiology at the Swedish American Hospital in Rockford, Ill.

1967

EDWARD M. FINEBERG has joined the department of ophthalmology at the Medical College of Georgia as associate professor. His special area of interest is retnal surgery.

1969

JOYCE R. ADAMSON is working part-time at Boston's South End Community Health Center, at the Tufts Student Health Service, and as a medical consultant to the psychiatric service at New England Memorial Hospital in Stoneham, Mass. She was elected to the Board of Health of Stoneham in March. Her twins turned three years old in August.

CONSTANCE ANTON BARKER and her husband, JEFFERY (BUSM '69), have two children, Alexandra, age 4, and Olivia, 1. Jeff does research in neurobiology at the National Institutes of Health, and Constance, who has a private practice in psychiatry, is a candidate in training at the Washington Psychoanalytic Institute.

ROBERT A. DYE has completed the last year of a cardiology-fellowship training at Peter Bent Brigham Hospital in Boston, and began a practice of adult and pediatric cardiology at Peter Bent and Children's Hospital Medical Center. He will also join the faculty of Harvard Medical School as a research associate. He writes he is "enjoying being a pre-medical adviser to a group of future BUSM students who are in the class of '80 of the Six-Year Medical Program."

BARBARA HERMAN FLEMING has joined the staff of the Cleveland Veterans Administration Hospital in the department of medicine as an endocrinologist. Her husband works in pulmonary research. Their son, Kevin, is four years old.

GEORGE W. RICE is an assistant to the Board of Health of Stoneham in March.

1970

JEREMY CHESS announces the opening of his office for the practice of ophthalmology at the Norwalk Medical Center, 158 East Ave. Norwalk, Conn.

1971

MARTIN M. BRESS has completed two years in the National Health Service Corps as a medical director of the Hollister Medical Center in California and is now a senior resident in internal medicine at the Boston Veterans Administration Hospital.

CAROL O'NEIL is currently with Tufts Medical School, dividing her time between its Student Health Service and the Little House Health Center in Dorchester, Mass., one of the newer community-run centers. She plans to take the Family Practice Boards in the fall.

1972

JAMES R. BRASLE has begun a psychiatric residency at Barnes Hospital, Washington University School of Medicine in St. Louis, Mo. He is in child psychiatry research.

DAVID R. ROWDEN has completed his residency in internal medicine at the Upstate Medical Center in Syracuse, N.Y., and has started a fellowship in gastroenterology there.

ELISABETH B. SIMMS is now living in Washington, D.C., and will be senior resident in internal medicine at the Washington Hospital Center. Her husband, Larry, is working as a law clerk in the Supreme Court. They have a daughter, Anna Melissa, age 1.

1973

STEPHEN GOLDBERGER has completed two years in surgery at the Montefiore Hospital in the Bronx, N.Y., and has begun an ENT residency at the University of California, Irvine. Regards and thanks to Dr. M. Stuart Strong.

EVA E. MORTIMER is a second-year resident in obstetrics and gynecology at Madigan Army Medical Center in Tacoma, Wash. He was married to Rosemary Sullivan (BU School of Nursing) in May, 1975.

MICHAEL STRONGIN and his wife have a son, Jason Mark, born in March, 1974.
after taking a potent analgesic 360 times in 3 months...
how big a dose will now bring relief if it is a narcotic?

"Tolerance is an ever-present hazard to continued use of narcotics.... The very first dose diminishes the effects of subsequent doses." And, as increasing amounts of narcotics are required to control pain, distressing adverse effects — lethargy, hypotension, constipation, etc. — can needlessly debilitate the patient.


how big a dose will now bring relief if it is Talwin?

Chances are, the same 50 mg. Talwin Tablet you prescribe originally will continue to provide good pain relief. Talwin can be compared to codeine in analgesic efficacy: one 50 mg. tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. However, patients receiving Talwin Tablets for prolonged periods face fewer of the consequences you've come to expect with narcotics. There should be fewer "adverse effects" on her way of life.

Tolerance rare: Tolerance to the analgesic effect of Talwin Tablets is rare.

Dependence rare: During three years of wide clinical use, there have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.*

Generally well tolerated by most patients*: Infrequently causes decrease in blood pressure or tachycardia; rarely causes respiratory depression or urinary retention; seldom causes diarrhea or constipation. Acute, transient CNS effects, described in product information on following page, have occurred in rare instances following the use of Talwin Tablets. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects may decrease or disappear after the first few doses.

*See important product information on next page for adverse reactions, patient selection, prescribing and precautionary recommendations.

in chronic pain of moderate to severe intensity

Talwin® 50 mg. Tablets
brand of pentazocine (as hydrochloride)
in chronic pain of moderate to severe intensity

Talwin® Tablets brand of pentazocine (as hydrochloride) Analgesic for Oral Use

Indication: For the relief of moderate to severe pain.

Contraindication: Talwin should not be administered to patients who are hypersensitive to it.

Warnings: Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

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Head Injury and Increased Intracranial Pressure. The respiratory depressant effects of Talwin and its potential for use in patients having spinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those associated with commonly used anesthetics. Talwin should be used with caution in women delivering premature infants.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

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.

Precautions: Certain Respiratory Conditions. Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. 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.

Myocardial Infarction. As with all drugs, Talwin 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.

Patients Receiving Narcotics. Talwin is a mild narcotic antagonist, prolonged administration of narcotics, including methadone for the daily treatment of narcotic dependence, have experienced withdrawal symptoms after receiving Talwin.

CSS Effect. Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such instances. Abrupt discontinuance after prolonged use or overdose may result in withdrawal symptoms.

Adverse Reactions: Reactions reported after oral administration of Talwin include gastrointestinal: nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. CNS effects: dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see Acute CNS Manifestations under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. Autonomic: sweating; infrequently flushing and rarely chills. Allergic: infrequently rash; and rarely urticaria, edema of the face. Cardiovascular: infrequently decrease in blood pressure, tachycardia. Hematologic: rarely depression of white blood cells (especially granulocytes), usually reversible and usually associated with diseases or other drugs which are known to cause such changes, moderate transient eosinophilia. Other: rarely respiratory depression, urinary retention, toxic epidermal necrolysis.

Dosage and Administration: Adults. The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

Children Under 12 Years of Age. Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have received orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

Overdosage: Manifestations. Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition. Treatment. Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation with the use of Talwin although no cause and effect relationship has been established.

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Matters of Record

Grants and Contracts

May, 1975

School of Graduate Dentistry

- Studies on proline-rich proteins from human parotid and submandibular secretions. F. Oppenheim. NIH. $25,000. 6/1/75-5/31/76.
- Microvascular lesions of buccal and gingival tissue. S. Anapolle. NIH. $21,172. 6/1/75-5/31/76.

School of Medicine

- Interdisciplinary program in biomaterials science. A. Essig. NIH. $80,000. 1/1/75-12/31/75.
- Hypotension, renal ischemia and effect of mannitol. N.G. Levinsky. NIH. $100,000. 5/1/75-4/30/76.
- Training in anatomy. A. Peters. NIH. $349,796. 7/1/75-6/30/76.
- Long-term effects of opiates on progeny. G. Friedlar. NIH. $664,391. 2/1/75-1/31/76.
- Chemistry of human proteins and glycoproteins. K. Schmid. NIH. $111,071. 10/1/74-9/30/75.
- The epidemiology of stroke. T.R. Dawber. NIH. $389,598. 5/1/75-4/30/76.
- Respiratory disease. E. Gaensler. NIH. $72,540. 7/1/75-6/30/76.
- Regulation of tumor growth by transmembrane potential. A. Politoff. NIH. $70,950. 6/1/75-5/31/76.
- Biosynthetic alteration of sickle hemoglobin. R. Troxler. National Foundation of March of Dimes. $26,500. 7/1/75-6/30/76.
- Aging in connective tissue, brain and auditory system. F.M. Sinex. NIH. $153,160. 6/1/75-5/31/76.
- Elastin structure and disease. J. Foster. NIH. $25,561. 5/1/75-4/30/76.
- New careers training. L. Peters. NIH. $72,810. 7/1/75-6/30/76.
- Diabetes mellitus: role of coxsackievirus B infection. S. Kibrick. NIH. $37,282. 6/1/75-5/31/76.
- Regional flow in experimental myocardial infarction. W. Hood. American Heart Association. $16,280. 7/1/75-6/30/76.
- Neurobehavioral studies in petit mal epilepsy. A. Mirsky. NIH. $41,995. 6/1/75-5/31/76.

June, 1975

School of Graduate Dentistry

- General research support grant. H. Wells. NIH. $31,114. 1/1/75-12/31/75.
- Health professions capitation grant. H. Goldman. NIH. $168,614. 7/1/75-6/30/76.
- Training in expanded auxiliary management. A. Jong. PHS. $261,619. 7/1/75-6/30/76.

School of Medicine

- General clinical research center. E. Fineberg. NIH. $18,232. 10/1/74-9/30/75.
- Biological role of vitamin E in cell culture. L.W. Corwin. NIH. $22,366. 5/1/75-4/30/76.
- Emotion and pulmonary function in asthma. P.H. Knapp. NIH. $65,809. 6/1/75-5/31/76.
- A new cycle for ammonia production in the kidney. L.M. Lowenstein. NIH. $33,456. 6/1/75-5/31/76.
- Role of cyclic AMP system in cancer. A. Rutenberg. American Cancer Society. $60,000. 7/1/75-6/30/76.
- Decreased insulin sensitivity in diabetes mellitus. S.E. Fineberg. NIH. $37,140. 6/1/75-5/31/76.
Psychopharmacological studies of attention. C. Kornetsky. NIH. $31,860. 7/1/75-6/30/76.

Career development award--immunology of viral leukemia and its treatment. M. Bennett. NIH. $25,000. 6/1/75-5/30/76.

Training for research on the biochemistry of aging. F.M. Sinex. NTH. $76,198. 7/1/75-6/30/76.

Pulmonary biochemistry and cell biology. J.S. Brody. NIH. $58,586. 7/1/75-6/30/76.

Support drug epidemiology unit. D. Slone. Hoffman-LaRoche. $30,000. 7/1/75-6/30/76.

International fellowship award--A. Zavarine. NIH. $18,000. 7/1/75-6/30/76.

Immunologic mechanisms of glomerular injury. W. Couser. NIH. $21,608. 6/1/75-5/31/76.

Health professions special project grant for preceptorship training. C. R. Dawber. NIH. $348,096. 6/30/75-9/30/78.


Characterization of membrane transport systems. A. Sullivan. NIH. $25,000. 7/17/75-6/30/76.

Adaptive process in infant environment. L. Vachon. NIH. $67,050. 6/16/75-6/15/76.

Training grant in rheumatology. A. Cohen. NIH. $96,172. 7/1/75-6/30/76.

Allergy and infectious disease. W. McCave. NIH. $73,616. 7/1/75-6/30/76.

Supplementary radiologists. B. Messer. Pondville Hospital. $66,795. 7/1/75-6/30/76.

Animal model of pulmonary fibrosis. C. Snider. NIH. $67,050. 6/16/75-6/15/76.

Protecting ischemic myocardium and minimizing infarct size: experimental interventions and studies fundamental. W.B. Hood. NIH. $112,371. 6/30/75-6/29/78.


New careers in mental health. R. Batson. NIH. $40,000. 7/1/75-6/30/76.

Roxbury court alcoholism screening/referral program. J. Wells. NIH. $108,839. 10/1/75-9/30/76.

A comprehensive drug utilization program. C. Franzblau. NIH. $424,369. 6/29/75-6/28/76.

Training grant in dermatology research. H. Mescon. NIH. $74,501. 7/1/75-6/30/76.

Research plan for evaluation of the effectiveness of the concurrent utilization review requirements of Medicare. (C). P. Levinsky. Social Security Administration. $76,376. 7/1/75-12/30/76.

Arthritis clinical research center. A. Cohen. Arthritis Foundation. $20,000. 7/1/75-6/30/76.

Institutional grant. A. Cohen. Arthritis Foundation. $31,518. 7/1/75-6/30/76.

Metabolism of a long-acting oral contraceptive. H. Wotiz. NIH. $33,500. 6/30/75-6/31/76.

Center for behavioral studies in addiction. J. Cochin. Harvard University. $57,178. 6/1/75-6/31/76.

Health professions capitation grant. J. Sandson. NIH. $84,601. 7/1/75-6/30/76.

Training grant in ophthalmology. H. Leibowitz. NIH. $67,861. 7/1/75-6/30/76.

Alcoholism training for paraprofessionals. C. Rosenberg. NIH. $66,558. 7/1/75-6/30/76.

Multidisciplinary pulmonary training program. C. Franzblau. NIH. $24,367. 7/1/75-6/30/76.

Clinical cancer education program. P.J. Mozden. NIH. $18,920. 7/1/75-6/30/76.

Long term training in rehabilitation medicine. M. Freed. NIH. $84,279. 7/1/75-6/30/76.

Undergraduate psychiatry. P.H. Knapp. NIH. $41,524. 7/1/75-6/30/76.

Basic residency. P.H. Knapp. NIH. $223,776. 7/1/75-6/30/76.

Training for minority group psychology students. C.G. Seymour. NIH. $106,750. 7/1/75-6/30/76.

Child neurology. N. Rosman. NIH. $18,993. 7/1/75-6/30/76.

Psychiatry-research training. S. Fisher. NIH. $130,788. 7/1/75-6/30/76.

Research training in nephrology. N. Levinsky. NIH. $39,057. 7/1/75-6/30/76.

Program in rheumatology. A. Cohen. NIH. $19,529. 7/1/75-6/30/76.

General clinical research center. J. Sandson. NIH. $18,232. 10/1/74-9/30/75.

Health professions student loan. J. Sandson. NIH. $30,000. 7/1/75-6/30/76.
Sandson. PHS. $29,698. 7/1/74-6/30/75. 

University Hospital
Defense mechanism in gram-negative bacteremia. W. McCabe. NIH. $30,656. 6/1/75-5/31/76.

Hemopoiesis in megaloblastic anemias. L. Sullivan. NIH. $96,021. 6/1/75-5/31/76.

Methodology of outpatient drug research. S. Fisher. NIMH. $178,557. 9/1/74-8/31/75.

The cause of joint homograft failure. I.G. Yablon. NIH. $71,005. 9/1/75-8/31/76.

Biochemical and physiologic response to trauma. R.H. Egdahl. NIH. $176,277. 9/1/75-8/31/76.

Biology and immunology of gram negative bacilli. W.R. McCabe. NIH. $65,900. 9/1/75-8/31/76.

Antilipemic regimes in peripheral arteriosclerosis. J. Coffman. NIH. $29,778. 9/1/75-8/31/76.

Sphincter strength - its measurement and control. L.D. Harris. NIH. $35,400. 9/1/75-4/30/76.

Mechanisms regulating adrenocortical secretion. J. Melby. NIH. $61,752. 6/1/75-5/31/76.

Clinical metabolic research unit. J.C. Melby. NIH. $166,271. 10/1/75-9/30/76.

Hypertension, shock and circulatory failure. A.V. Chobanian. NIH. $278,271. 10/1/75-9/30/76.

IN PRINT


An admittedly "profoundly radical" approach to health care, in which Carlson (a research attorney with the Health Services Research Center, Interstudy, Minneapolis, and a consultant to the Institute of Medicine at the National Academy of Sciences) argues that, since our enormously expensive medical-care system has very little real impact on health - less than social and environmental factors have - we should dismantle it and start over. "A leaner and tougher approach to health can be created out of the remains of the current delivery system. The new approach will build on those things that generate health; unlike present-day medicine, it will not rely on profound interventions when health has been lost."

GEORGE J. ANNAS, J.D., M.P.H., director of the Center for Law and Health Sciences of the Boston University School of Law, The Rights of Hospital Patients. Avon Books, 1975. 246 pp. $1.50 (paper). An American Civil Liberties Union handbook designed to inform both consumers and health-care providers of the legal rights of hospital patients; with special attention to the rights of children, women and the dying, and separate chapters on human experimentation, informed consent, and legal actions patients can take against doctors and hospitals. To ensure the protection of rights, Anna8 argue for introduction of a patients' rights advocate in every hospital.

ALVIN N. EDEN, M.D., Class of '52, Growing Up Thin (with Joan Fattner Heilman). David McKay Co., 1975. 223 pp. $7.95. Detailed, valuable guide for parents to the prevention and treatment of obesity in children from infancy through adolescence. Eden is director of pediatrics at Wyckoff Heights Hospital in Brooklyn, N.Y., associate clinical professor of pediatrics at New York University School of Medicine, and has been a practicing pediatrician for 20 years.

Centerscope would like to know about all recently published or soon-to-be-published books and monographs (and articles of unusual interest) by Medical Center staff, faculty or alumni. Please call Lorraine Loviglio at the Office of Informational Services, (617) 267-3611.

Changes in title

(effective July 1, 1975)

School of Medicine
John K. Carpenter: To Assistant Clinical Professor of Medicine.
Patricia F. Chappel: To Assistant Professor of Psychiatry.
Alan H. Goldberg: To Professor of Anesthesiology.
Daniel K. Kovnat: To Assistant Professor of Medicine.
Jaroslav P. Mikus: To Instructor in Medicine.
Carl B. Sherter: To Assistant Professor of Medicine.

School of Graduate Dentistry
Philip Maloney: To Clinical Professor of Oral Surgery.

Douglas W. Stewart: To Assistant Professor of Endodontics.

Appointments

(effective July 1, 1975, unless otherwise noted)

School of Medicine
Anthony G. Bonacci: Instructor in Pe-
Minority representation in health care administration
(Continued from pg. 4)

1974 were female. We don't bother to count until we're a few weeks into the semester, so the results for the fall of 1975 aren't known yet. My impression is that we may well have 55 per cent to 60 per cent females in our entering class.

Women may continue to be a minority of the full-time students; they will be a clear majority of the part-time students. The availability of a part-time program is crucial to development of a capable cadre of female health managers.

Blacks, Puerto Ricans, Chicans and American Indians face a distinctly different problem, one that is not self-curing. The problem has become a major concern of the Association of University Programs in Health Administration (AUPHA) in cooperation with the (predominantly black) National Association of Health Service Executives (NAHSE). I'm delighted to now be serving my second year as chairperson of AUPHA's Committee on Minority Group Affairs.

In our perception, the major problem is lack of visibility. Promising minority undergraduate students know about law and medicine; they've never heard of health-care management. A summer work-study program is our device for changing that situation. Promising minority undergraduates are attracted to the program by the promise of a paid summer job. During the summer they have a chance to work with and observe health-care managers in action. Special educational opportunities and tours further expand the students' knowledge of health administration and allow them to get a fuller view of a prospective career. The summer work-study program is just completing its fifth year. A total of about 400 students were involved in the first four years. The program was conducted in six cities during the summer of 1974. During the past summer we expanded the program a great deal, with nearly 300 students participating in 21 cities. Boston was one of the cities added this year—and indeed the program here made the term "cities" inappropriate for a summer program: With the strong backing of the Massachusetts Hospital Association, Massachusetts Blue Cross, and the Veterans Administration, it became a state, not a city, program.

Local and national funding:

Local funding sources were Blue Cross and the participating institutions. The Boston effort was also helped with substantial funds from national sources assembled by AUPHA.

Locally and nationally, our goal for next summer is to strengthen and solidify the program, after the major expansion of the summer of 1975. It will be a few years before we know whether such a program has led to an increased flow of minority candidates into graduate programs in health-care management and into careers in health management.

If and when there is an upswing in such qualified applicants, we hope the second major component of the AUPHA minority program will be ready—a program of scholarship and loan fund for minority students.

R. Hopkins Holmberg
Director, Health Care Management Program,
School of Management
Since 1812, The New England Journal of Medicine has played its role in medical circles—reporting the progress of medicine to physicians and medical students throughout the world.
Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatologic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindications:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

If there’s good reason to prescribe for psychic tension...

When, for example, reassurance and counseling on repeated visits are not enough

**Effectiveness is a good reason to consider Valium (diazepam)**

2-mg, 5-mg, 10-mg tablets