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Matters of Record

School of Medicine graduates hear Dr. Byrne; Dr. Goldman addresses SGD commencement

The 122 members of the School of Medicine's graduating class heard a warning by faculty member John J. Byrne, M.D., May 23 that they are beginning their careers in a world becoming increasingly wary of the physician.

Describing the doctor-patient relationship of former days as "one of the most beautiful relationships invented by man," Byrne blamed the high cost of medical care for what he described as the current breakdown in doctor-patient relations. "Great advances in medicine are being pooh-poohed in the light of economics," he said.

A noted hand surgeon, Byrne is a School of Medicine professor of surgery, director of the Hand Service at the Medical Center and director of the BUMC Student Surgical Teaching Program. He was president of the New England Surgical Society last year.

Addressing the new physicians at the Case Center on BU's Charles River Campus during Class Day Exercises following the University commencement, Byrne stated that the high cost of medical care has created a demand for a scapegoat. "The doctors who order the tests, who invent and demand the electronic life-saving equipment, and who perform the complex operations are the targets," he said.

He advised physicians to unite in such organizations as the American Medical Association and local medical societies, which, he said, are better equipped than individual doctors to hear patients' complaints, define the real problems, and attempt to find solutions through a dialogue with patients, legislators, and government agencies. The purpose of such organizations must be to advance the welfare of the patient and not of the physician, he emphasized.

The 91 men and 31 women in the graduating class, which included one married couple, received their M.D. degrees from School of Medicine Dean John I. Sandson, M.D. The graduates come from 19 states, with one-third of the class from Massachusetts.

Also holding its commencement May 23 was the School of Graduate Dentistry, which awarded 61 advanced degrees to dentists from 22 states, the District of Columbia and 13 foreign countries. Twenty-three graduates were from Massachusetts. In addition, 11 graduates were awarded the master of science degree in dental public health. Five students received the D.M.D. degree, upon completing the requirements of the School's predoctoral dental program. (The 10 postdoctoral candidates in orthodontics received degrees on June 30.)

SGD Dean Henry M. Goldman, D.M.D., was speaker at his school's commencement ceremonies, which were held in the auditorium of the Boston University School of Law. Morris P. Ruben, D.D.S., assistant dean for the postdoctoral program, presided.

SCHOOL OF GRADUATE DENTISTRY

The following is a list of 1976 graduates of the School of Graduate Dentistry, their hometowns and degrees or certificates received. Awarded were the Master of Science (M.S.), Master of Science in Dentistry (M.Sc.D.), Doctor of Science in Dentistry (D.Sc.D.), and the Certificate of Advanced Graduate Study (C.A.G.S.). The graduates are listed by specialty. Also in-
cluded are the names and hometowns of those persons completing requirements for the D.M.D.

**DOCTOR OF DENTAL MEDICINE**


Frank Gordon Oppenheim, Ph.D., Ennetbaden, Switzerland


Marvin Zach Schreiber, M.D., Pembroke Pines, Fla.

**COMMENCEMENT ’76**


**DENTAL PUBLIC HEALTH**


Aviva Judith Barber, Brookline, Mass. (M.S.)

Mary T. Burns, Springfield, Pa. (M.S.)

Gail N. Cross, Denver, Colo. (M.S.)

Jane Leslie Forrest, Washington, D.C. (M.S.)

Janis G. Kaufman, Swamscott, Mass. (M.S.)

Madalyn Leslie Mann, Miami, Fla. (M.S.)

Linda Sue Schey, Bloomfield, Mich. (M.S.)

Kathleen Gail Smith, Santa Rosa, Calif. (M.S.)

Sr. Sheila A. Stevenson, Rochester, N.Y. (M.S.)

Mary Jane Vallee, Marlboro, Mass. (M.S.)

Gail Purrington Winkley, Winchester, Mass. (M.S.)

**ENDODONTICS**


Lewis J. Levitan, D.D.S., Dallas, Tex. (C.A.G.S.)


Ira B. McKinley, D.D.S., Anchorage, Alaska (C.A.G.S.)


William Armstrong Shelton, Jr., D.D.S., Chattanooga, Tenn. (M.Sc.D.)

Gary Louis Spieler D.D.S., Queens, N.Y. (C.A.G.S.)


**MAXILLOFACIAL PROSTHETICS**


**NUTRITIONAL SCIENCE**

Brenda Louise Cronin, Arlington, Mass. (M.S.)

Wayne B. Hickory, Windsor, Conn. (M.S.)

**ORAL BIOLOGY AND PATHOLOGY**


**ORAL MEDICINE**

Behjat Khadrevand Moghadam, D.D.S., Tehran, Iran (C.A.G.S.)

**PEDODONTICS**


LAST-MINUTE DETAILS are discussed by, left to right, Drs. Spencer N. Frankl, Donald P. Mori and Henry M. Goldman before the School of Graduate Dentistry commencement exercises begin.


PERIODONTOLOGY
Richard Franklin Caudill, D.M.D., Ashland, Ky. (C.A.G.S.)
Leo Gerzuk, D.D.S., Montreal, Canada (C.A.G.S.)

Mark Alan Rosen, D.D.S., Skokie, Ill. (C.A.G.S.)

COMMENCEMENT '76

Yousri Zarif Said, D.D.S., Cairo, Egypt (C.A.G.S.)
Allen Shapiro, D.D.S., Montreal, Canada (C.A.G.S., M.Sc.D.)
Melba Adams Wilson, D.D.S., Toledo, Ohio (C.A.G.S.)
Jean-Claude Maurice Yulzari, D.D.S., Metz, France (C.A.G.S.)

PROSTHETIC DENTISTRY
Kirby Clements, Sr., D.D.S., Atlanta, Ga. (C.A.G.S.)
Bruce J. Etkin, D.D.S., Fort Lauderdale, Fla. (C.A.G.S.)

Robert Frankel, D.M.D., Flushing, N.Y. (C.A.G.S.)

Gerald Brian Kaplan, B.D.S., Johannesburg, South Africa (M.Sc.D.)


COMMENCEMENT '76


David Norman Wessel, D.M.D., Pittsburgh, Pa. (C.A.G.S.)


ORTHODONTICS

(Graduation ceremony June 30, 1976)


Carl Steven Gulrich, D.M.D., Mahwah, N.J. (C.A.G.S., M.Sc.D.)

Ahmed A. Al Jasem, B.D.S., Kuwait (C.A.G.S.)


SCHOOL OF MEDICINE

The following is a list of the BUSM graduates, their hometowns, residency placements and residency categories.

** magna cum laude  
* cum laude

Alyce R. Adams, Farmerville, La.; Harlem Hospital, New York, N.Y.; internal medicine.

Neal K. Anderson, Randolph, Mass.; Veterans Administration Hospital, Boston, Mass.; internal medicine.

Peter L. Babinski, Jr., Point Pleasant Beach, N.J.; Overlook Hospital, Summit, N.J.; flexible.

Marilyn E. Banks, Wayneboro, Ga.; Roger Williams General Hospital, Providence, R.I.; internal medicine.

John M. Battista, Bronx, N.Y.; United Health & Hospitals, Kingston, Pa.; family practice.


Edward R. Berman, Brooklyn, N.Y.; Wayne State University Affiliated Program, Detroit, Mich.; internal medicine.

Randolf A. Birken, Valley Stream, N.Y.; Baylor College Affiliated Hospitals, Houston, Texas; obstetrics-gynecology.

Scott Blumberg, Freehold, N.J.; Jacksonville Education Program, Jacksonville, Fla.; internal medicine.

**Bennett Blumenkopf, Brooklyn, N.Y.; Duke University Medical Center, Durham, N.C.; surgery.

Jeffrey R. Breiter, Oceanside, N.Y.; Montefiore Hospital Center, New York, N.Y.; internal medicine.

Ben R. Bronstein, Manchester, N.H.; Royal Victoria Hospital, Montreal, Canada; surgery.

Don R. Buswell-Charkow, Arlington, Mass.; Veterans Administration Hospital, Boston, Mass.; internal medicine.

James C. Caccia, Watertown, Mass.; Veterans Administration Hospital, Boston, Mass.; internal medicine.

William E. Caplan, New Bedford, Mass.; Veterans Administration Hospital, Boston, Mass.; internal medicine.

Pramodhya Chirasevinupraphand, Wellesley, (Continued on Page 37)
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Cover: Design by Jerome Schuerger; photography by C. John MacFarlane, Boris Studio.
Photography: Pages 1, 3, 30 (top, lower right), 31; 32 — Harry Trask; 10 (top), 12, 13, 14, 16, 17, 18, 19, 23, 30 (lower left), 37, 38, 39 — Bradford Herzog; 24 — Maureen Stratford; 26 — Charles Boyter, BUMC Educational Media Support Center; 27, 28 — Diane Simmons.

JoAnn Brown, R.N., directs University Hospital’s recently opened stoma clinic. Page 9.
Was it just 'housewifitis' — or was it her hobby?

Centerscope's "Research in Progress" feature usually records the current status of a particular basic or applied research project at the Medical Center. This edition instead examines how an ongoing study in the BUMC Department of Neurology particularly affected a single human being who, at the end of a long search for help, fortunately made contact with Dr. Robert G. Feldman, chairman of the department. — Editor.

About two years ago, Toby Sedman, Brockton housewife and mother of three, began feeling a tightness in her neck and a heaviness in her arms. She went to see her general practitioner, who examined her and told her she had a bad case of "housewifitis." She should get out in the world, he said. Develop some interests.

Sedman thought she already had interests. Besides caring for the house and children, she had a money-making hobby. She had taught herself from hobby books to make the little leaded-glass ornaments that people hang in windows to catch the light, and had been selling them on consignment to a local gift shop.

First, she cut colored glass into jigsaw-like pieces, then wrapped each piece in a strip of channeled lead, and, finally, soldered all the pieces together to form the completed figure.

A pinched nerve? When her symptoms got worse, Sedman called a local hospital, which recommended an orthopedic specialist. He decided that a nerve in her neck was pinched and put her in a collar. She wore the collar for a month, but she had begun to feel nauseated and to have cramps in her groin and stomach. She thought the gas pedal in her car wasn't working; then she realized that the trouble wasn't with the pedal, but with her right leg, which had become weak.

"By this time, my tongue was heavy and I was slurring my words," Sedman says. "I went back to my GP and told him about it, and he told me again I had housewifitis and I should join an organization."

In October the family pediatrician, who knew about her work with lead, suggested she go to the local nursing association for a check of the lead level in her blood. "The nursing association told me I had lead poisoning and should see a neurologist. When I asked for the name of one, they gave me the names of three internists instead, and I made an appointment with one of them."

This doctor did another blood lead-level test, said there was nothing wrong, and suggested it might be her arthritis kicking up. (Sedman has a very mild form of arthritis.) "At that point I was beginning to fall a lot," she says. "My left ankle would give way, and when I went marketing I dropped the bundles all over the driveway. I kept spraining my ankle, and it would swell up so much I was sure it was broken. I was almost constantly at a local hospital, and they would say, 'Whatever you're doing to cause these sprains, you'd better stop.' I'm sure they thought I was on drugs or alcohol."

A call to BUMC's Feldman. Almost in despair, and beginning to think she must be crazy, Sedman next turned to a friend, George S. Kurland, M.D., an internist at Beth Israel Hospital. After examining her thoroughly, Kurland immediately called Robert G. Feldman, M.D., chairman of the neurology department at BUMC. Feldman had been successfully diagnosing lead poisoning in persons whose blood showed relatively low lead levels by means of a test that measures how fast a patient's nerves can carry an impulse from one point in the body to another. Persons chronically exposed to low levels of lead in their environment may carry an increased body burden of lead — that is, lead stored in nerve tissues, teeth, bone, muscle and other organs — that may not show up in a blood test. In such persons, nerve impulses are slowed due to damage to the coverings of the nerves.

When the nerve conduction velocity test on Sedman was positive for lead poisoning, Feldman had her admitted to University Hospital for several days for detoxification. After about a month, she was beginning to function normally again.

Although she knew she would always be a bit more susceptible to lead poisoning than other people, Sedman — who describes herself as a fatalist — continued to work with leaded glass, and her business grew to the point where she was selling wholesale to several gift shops. She wore a commercial-type face mask with filters, used disposable surgical gloves, and worked in a carefully ventilated room.

Medical problems linger. Last May she opened her own small shop in the Taunton Mall, selling tapes and records of old radio shows of the thirties and forties and other nostalgia items. A few stained-glass pieces hang in the windows of the shop. While she emphasizes that she is a healthy, self-sufficient person today, Sedman has not seen the end of her lead-related medical problems. She stopped working with leaded glass last February when two fingers of one hand became stiff and numb, and in June she entered University Hospital for corrective surgery on her hand.

In a letter to the editor about the case that appeared in the New England Journal of Medicine April 25, 1975, Feldman reported that he and Sedman had conducted an informal study of craft books and craft-kit instruction sheets and had interviewed suppliers and teachers of the craft. They discovered an almost complete lack of awareness of possible harmful long-term effects from working with leaded glass. The one hobby book they found that did mention lead poisoning claimed it was caused by poor hygiene, finger licking, and eating while working.

According to Sedman, this is simply nonsense. "I always kept my work area spotless, and I wore bandages on my fingers to protect myself from glass cuts. As for eating while working — it is simply ridiculous to imagine" (Continued on page 13)
Sail Boston This Summer

The Boston Harbor Sailing Club, a membership sailing program at Harbor Towers in Boston invites you to sail Boston this summer. Membership in the club is open to the public and a single yearly fee gives you virtually unlimited use of our fleet of 27 foot solings, the solid, stable keelboat that was selected for use in the Olympic Games. All sailing is done on Boston Harbor and adjacent waters. For those interested in racing there is a twice-weekly competition program.

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Childbirth and court: The wrong issue in the wrong forum?

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

While most courtroom confrontations involving childbirth concern parents seeking damages for alleged physician and hospital negligence, a number of recent cases have involved parents seeking simply to have their babies with a minimum of medical intervention. Courts, however, have consistently deferred to "expert" medical opinion in this area.

The extreme reluctance of courts to substitute their judgment for that of hospital boards is nowhere better illustrated than in the cases involving fathers in the delivery room. While most hospitals with maternity wards currently permit "husband-coached" (Lamaze or psychoprophylactic being the most common method) childbirth, in which the father is with the mother throughout labor and delivery, supplying physical and emotional support, lawsuits to compel a change in the policies of those institutions that do not have been universally unsuccessful to date. This is true regardless of whether the hospital is private or public or whether the plaintiff is a pregnant woman or her obstetrician.

Montana court action. In the first appellate decision on this question, a Montana court reversed a lower-court ruling in favor of an obstetrician who had challenged a hospital rule that forbade the presence of fathers in the delivery room. The administrator of the private Catholic hospital in question contended that the rule was based on a concern for the spread of infection, chance of an increase in malpractice suits, possible disturbance of physicians in the doctors' locker room, increased costs of surgical gowns, potential for invasion of the privacy of other patients, as well as being considered a measure for the promotion of staff harmony.

Without analyzing the merits of these contentions, the court concluded simply that, as long as minimal due process was accorded the physician and the rule adopted was not arbitrary or capricious, the court would not intrude itself "into the administration of the hospital where the hospital had acted in good faith on competent medical advice." The only other case to reach the appellate level in this area involved a suit by prospective parents against a public hospital. They contended that the hospital's policy denying fathers a right to be in the delivery room violated the first, fourth, ninth and 14th amendments of the United States Constitution, with specific reference to the "right of marital privacy" enunciated in the birth control and abortion decisions. The lower court dismissed their suit. On appeal the court affirmed the dismissal in a 2-to-1 decision, with Judge John Paul Stevens writing the majority opinion shortly before his elevation to the United States Supreme Court. In so doing it made a number of comments that highlight the problems future courts will have to overcome before recognizing a constitutional right of a woman to have the father of her child with her during a hospital delivery.

Major barrier is precedent. Perhaps the most important stumbling block is that of precedent. The court was extremely concerned that it would have to find a constitutional right for a husband to be present in the delivery room during childbirth, they would also have to permit "unwed parents" such access, and "perhaps" be required as well to allow other persons about to undergo serious medical procedures the right to be accompanied by a person of their choice. While I would argue that this might be the most desirable result, I would strongly disagree with the court's view that it is a likely one. Childbirth can be distinguished in a number of ways from other procedures, in fact that it is a "natural" process happening to a healthy woman; from the fact that it is performed in these cases under local or no anesthesia; from the fact that it is primarily concerned with reproduction; or from a combination of these factors (although this would, and certainly should, apply to birth by cesarean section).

It was the court's inability to make such a distinction that reinforced their determination to find against the plaintiffs. In fact, while conceding that "the birth of a child is an event of unequalled importance in the lives of most married couples," the court found the birth procedure itself, "in its medical aspects," to be "comparable to other serious hospital procedures," and "extraordinary" in nature. This, of course, rejects the entire rationale of the "natural" childbirth movement, which is that childbirth is natural, not pathological, and that in the vast majority of births little or no medical intervention is either required or desirable.

The court finally noted that, since the plaintiffs only contended that they had a constitutional right to access if their physician consented to the husband's presence, they had themselves conceded that good medical practice might at some time require the exclusion of the husband, and consequently a hospital might have a rational basis for finding the entire procedure unjustifiable. This, and the recognized "dispute within the medical profession as to the propriety and safety of permitting the husband to be present during the routine birth," was enough for the court to conclude that it should not substitute its judgment for that of the hospital.

Minority view. Judge Speeches, however, would have reversed the lower court's ruling and remanded the case for a trial on the merits. He found that the "right of privacy" did extend to the delivery room, and that the evidence before the court (a 1968 survey of ICEA) demonstrated that of 45,000 Lamaze cases collected in surveys, "there was not one infection traceable to the practice and not one malpractice suit." He also cited with approval the affidavit of a professor of obstetrics and gynecology that was strongly favorable to the procedure. While he conceded that the deprivation of rights here was not of the magnitude that involved in the contraception and abortion cases (where access to drugs and medical services had been forbidden by criminal law) Judge Speeches noted that magnitude in this case as had been present in the previous cases, an interest that he described as "so noncompelling as to be virtually nonexistent: The hospital fears that the participating husband may catch a glimpse of other women in labor and that it does not have the facilities for him to don and doff his hospital gown." He concluded by arguing that denial of the woman's presence would be "unjustifiable. This, and the recognized constitutional right to access it their physician consented to the husband's presence when the woman desires it; at a critical time is unnecessarily, and I believe unconstitutionally, cruel to the expectant mother."

It is worth noting a number of points in this debate.

The first is that courts are likely to continue their tradition of granting hospital boards great latitude in adopting rules or bylaws that have any rational connection to improved patient care, and will enforce the application of such rules against individual physicians, provided that the hospital follows some minimal due-process requirements (usually set forth in the hospital's bylaws). Therefore, suits challenging hospital rules that prohibit certain procedures, such as Lamaze or Leboyer, are unlikely to be successful.

Secondly, it should be noted that while these two courts paid great deference to medical staff opinions that childbirth was "comparable to other serious hospital procedures," a California court has more recently ruled that childbirth is not a disease, but a "normal physiological function of women," and accordingly that "attending a woman in childbirth is not the practice of medicine under California law."
Third, red herrings, such as a potential rise in malpractice suits, should not be permitted to blur the real issues. If the courts were convinced that the concealment of malpractice by physicians was the primary reason for denying fathers access to the delivery room, it is highly unlikely that they would sanction such an exclusionary policy. While at least two fathers have sued for emotional trauma suffered by witnessing "the alleged negligent delivery of their children" (both infants were stillborn), it should be noted that both of these cases were dismissed. The court, dismissing the cases on a technical ground, noted that the cases would probably have failed on the independent ground that the fathers were voluntary witnesses to the tragedy, and thus consented to or assumed the potential risk of such a happening. The principal allegation, however, was negligence in the delivery and the suits would probably have been filed whether or not the father had been present.

A consumer rebellion. Finally, it should be apparent from this discussion that the courts are not the forum in which the real issues at stake are likely to be addressed. Those issues involved the desire of many couples to have a more human, joyful and family-centered experience during childbirth than is possible at many technologically oriented hospitals. It is a consumer rebellion against the medical model indiscriminately applied to all pregnant women that is at the heart of this debate. Moreover, the controversy has largely left this arena and will in the future be focused on maternity-care centers (clinics set up for the express purpose of providing family-centered deliveries) and homebirths.

While minor victories in this battle may be won in the courts, civil litigation, as illustrated by the "father in the delivery room cases," is not a terribly effective method of promoting safe alternatives to present childbirth methods. The proper arenas are likely to be the state legislatures and health regulatory agencies, and the proper issue is patient influence on the way childbirth services are delivered.

REFERENCES
1. As a result of a notice in the Fall, 1975 issue of the Newsletter of the International Childbirth Education Association, printed courtesy of ICEA President, Peg Beals, R.N., I have been informed of pending cases in St. Cloud, Minn., St. Joseph, Mo., Ft. Myers, Fla., and Baton Rouge, La., none of which have been successful through the decision-making process. The court said: "We need not here decide that issue, but will assume that such review is proper."
3. On the issue of whether there is a right to judicial review of a private hospital's decision-making process, the court said: "We need not here decide that issue, but will assume that such review is proper."
4. It is of interest to note that while the court lifted the temporary restraining order, the hospital has apparently continued to permit fathers in the delivery room. (Private communication, Peg Beals, Nov. 11, 1975.)
5. Fitzgerald v. Porter Memorial Hospital, 523 F.2d 716 (7th Cir. 1975).

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Kaleidoscope

Scholarships honor former BUSM deans Keefer and Bakst

The first awards of two new and highly prestigious scholarships were made in recent months to members of the BUSM Class of 1976. The first Chester Scott Keefer Scholarship was awarded to John G. Schneider. Named for the late Dr. Keefer, the former dean, chairman of the Division of Medicine, health adviser to President Eisenhower, and creative force in the creation of the Six-Year Program, the Keefer Scholarship is designated for "a student who embodies the ideal of excellence." Schneider, who comes from Cincinnati and is a graduate of the University of Michigan, will do his postgraduate training in medicine at Beth Israel Hospital in Boston next year.

The first Henry Jacob Bakst Scholarship was awarded to Charles R. McKay, a Boston resident and graduate of Northeastern University. To be awarded annually to a student "who has demonstrated the qualities that exemplify the true physician," the scholarship is named for Dr. Bakst, former dean of the School of Medicine, who held the title of Professor of Preventive Medicine, Emeritus, at his death in 1972, after 40 years of service to the School. McKay will go to Los Angeles County Harbor General Hospital next year for postgraduate training in Medicine.

University Hospital opens clinic for ostomy follow-up

For many persons, discharge from the hospital is a pleasant experience, filled with anticipation of resumed routine. But for the ostomate — a person who has had his or her bowel or bladder removed surgically and must live with an artificial opening in his abdomen — this is usually an anxious moment, for a number of significant emotional, social and financial adjustments must be made.

Period of doubt and transition. During this period of self-doubt and transition, many ostomates fear that they will never return to normal lives. But JoAnn Brown, R.N., of Belmont, director of University Hospital's recently opened Stoma Clinic, assures them that they will.

University Hospital opened a follow-up nursing clinic recently to provide medical and counseling services for ostomates on an outpatient basis. Families are also counseled as part of the service. Physicians serve as consultants at the nurse-run clinic.

"There is no one standard principle behind ostomy care, except cleanliness," Brown said. "The methods are flexible and are not learned overnight."

Brown follows patients throughout the pre-operative and post-operative periods. She meets the patient before
Counseling the recent ostomate, left, is a large part of JoAnn Brown's job as director of the University Hospital Stoma Clinic.

surgery, assists the nursing staff with ostomy care after the operation, and provides follow-up service after the patient goes home.

In addition to managing the Stoma Clinic, Brown, a surgical clinical specialist, teaches a six-week certificate course to graduate nurses on entero-stomal therapy, care of the ostomy patient, at the School of Nursing. The program, financed by a three-year National Cancer Institute grant, is the only such program in the country taught specifically for nurses.

Needs practical answers. Problems often arise for the ostomate after he has left the hospital, Brown said, though he may have learned to use his appliance, the bag into which stool or urine is drained. When an ostomate goes home, he asks himself, "How am I going to live now?"

He wants answers to practical questions, such as, "Will I have an unpleasant odor?" "Can I go back to work?" "What kind of clothes can I wear?" and "Can I travel?"

"I tell them," Brown said, "that anything they could do before the operation, they can usually do after it, with the exception of rough contact sports." Patients may also resume their normal diet, she said, after some experimentation.

Because one of the social problems colostomates and ileostomates face is control of intestinal gas, Mrs. Brown advises them to abstain from foods that gave them gas before the operation. But, she said, if an ostomate wants to eat a certain food, she suggests trying a little first, "and if it doesn't bother him, then I tell him to go ahead."

Brown said she has worked with ostomates who have traveled around the world, worn stylish clothes and competed in sports events. Women who have had ileostomies for ulcerative colitis may have children, Brown said, but women who have had cancer are advised against becoming pregnant.

University Hospital opened the Stoma Clinic to guarantee that all patients who want follow-up care once they leave the Hospital will receive it. "A patient can't absorb everything while he is in the hospital," Brown said, "and most patients are not ready to learn about their ostomy before or right after surgery."

"In my opinion," she added, "ostomy patients best learn how to care for themselves at home."

Ostomies increase five-fold. Brown said she has noticed a five-fold increase in the number of ostomies performed at University Hospital, a major New England research and referral center, since she joined the nursing staff five years ago. She attributed the rise to the Hospital's growing reputation as a center for advances in cancer diagnosis, treatment and management. Referrals from community hospitals have grown apace.

According to the American Cancer Society, there are approximately 10,000 ostomies in the Greater Boston area — and 1,100 new ostomates each year. After skin cancer, cancer of the bowel is the most common form of cancer. It affects men and women in almost equal numbers.

Cancer of the colon and rectum claims the lives of almost 48,000 Americans annually. However, recent statistical studies indicate an upward trend in the percentage of patients living at least five years after diagnosis. According to the National Cancer Institute, this improvement in the "survival rate" may result, in part, from an increase over the years in the percentage of patients treated with surgery.

The clinic is also open to walk-in patients and to ostomates who did not have surgery at University Hospital. Brown directs progress notes to the referring physician or institution.

The University Hospital Stoma Clinic, located at 70 East Newton St., is open Tuesday afternoons from 1:30 to 4.

Husband gives UH pump that eased his wife's last days

The infusion pump that supplied a 24-year-old cancer patient with vital nutrients enabling her to spend the last months of her life at her own home rather than in a hospital has been donated to University Hospital by her husband.

Linda Cordone Morrison, who was unable to digest food because of a tumor that obstructed the passage to her stomach, was the first person in Massachusetts and the second in New England to receive at home life-sustaining nutrients through an intravenous procedure called parenteral alimentation.

The process, usually administered in a hospital setting, has been used alone or in combination with oral feeding to provide cancer patients and persons with bowel disease, burns or other massive tissue destruction with their particular nutritional needs, according to William P. Steffee, M.D., director of the Clinical Nutrition Unit at UH. Parenteral alimentation, though not a treatment, per se, has been found in some cases to speed healing by allowing the digestive system to rest, he said.

Ms. Morrison was under the care of Steffee, assistant professor of medicine at the School of Medicine, and Peter J. Deckers, M.D., assistant professor of surgery in the Oncology Section.

Being home 'meant a great deal.' In donating the equipment — a $900
Volumetric Infusion Pump, manufactured by McGaw— to the Hospital, Ms. Morrison's husband, Bruce, said, "Getting Linda home meant a great deal to both of us. I really think being in her own home kept her alive for months." The two were married for almost three years.

With the pump, fluid formulated especially for the individual nutritional needs of the patient is drawn directly into the bloodstream through a subclavian catheter. Use of the pump allows control of not only the volume of solution the patient is to receive, but also the rate at which the fluid is infused.

"Giving this equipment to the Hospital so that others in our situation might have the same opportunities we had seemed to be the least I can do," Morrison said. Linda died in January, 1976.

N.E. Hospital group honors BUMC for two publications

Centerscope and its sister publication, Front & Center, the Medical Center's employee newspaper, were singled out for awards of excellence in the 1976 Awards Competition of the New England Hospital Public Relations Association.

Front & Center editor Nancy Haslam and Centerscope managing editor Owen J. McNamara accepted awards of special achievement for internal and external publications respectively at the NEHPRA honors ceremony at that organization's annual meeting held at Boston's Sheraton-Boston Hotel in conjunction with the New England Hospital Assembly in March.

Eleven other New England hospitals and their public-relations professionals were also honored in categories ranging from annual reports to special-projects publications. The hospitals, and the categories in which they were honored, were: annual report—Goddard Memorial Hospital in Stoughton, Mass.; and Central Vermont Medical Center in Burlington; patient information—Children's Hospital Medical Center in Boston; internal publications—University Hospital, Mt. Auburn Hospital in Cambridge, Mass., Newton-Wellesley Hospital in Newton, Mass., and Salem Hospital in Salem, Mass.; external publications—University Hospital, Newton-Wellesley Hospital, Massachusetts General Hospital in Boston, and Union Hospital in Lynn, Mass.; special-projects—Hunt Memorial Hospital in Danvers, Mass.; public-relations projects—Joseph P. Kennedy Memorial Hospital for Children in Boston, and Boston Hospital for Women.

Gardner honored for article on brain damage

Howard Gardner, Ph.D., assistant professor of neurology at BUSM in June was named one of two recipients of the 1975 Claude Bernard Science Journalism Award. His article, "Brain Damage: A Window on the Mind," winner in the magazine category, was reprinted from Saturday Review in the winter issue of Centerscope.

Alton Blakeslee of the Associated Press was given the award in the newspaper category for "Stalled Diseases," a series of seven articles on diseases that cannot yet be cured or prevented.

Honorable mentions were given to Judith Randal and George Leposky in the newspaper category, and Edward Edelson in the magazine category.

Responsible journalism recognized.

The articles, which to be eligible, must be printed in a newspaper or magazine of general interest, were given the awards in "recognition of responsible science journalism, contributing to the public understanding in the life sciences, including, but not limited to, experimental medicine." The award is given in memory of Claude Bernard, a 19th-century physiologist who is regarded as the founder of modern experimental medicine.

Trained as a developmental psychologist, Gardner has worked for the past four years with brain-damaged patients at the BUMC-affiliated Boston Veterans Administration Hospital as a neuropsychological researcher with the hospital's Aphasia Research Unit, a major activity of BUMC's Aphasia Research Center. He also studies the development of artistic skills in young children as co-director of Project Zero at Harvard University.


Translating service at UH has full-time leader, volunteer corps

When a non-English-speaking patient goes to the hospital in America, he is concerned about more than his health—he must worry about explaining the details of his problem to the physician.

Sensitive to the needs of patients and physicians in this situation, University Hospital recently instituted a bilingual service directed by a full-time translator. Staffed by volunteer Hospital employees, the service works with patients and medical staff to insure that medical and basic human needs are met.

From all departments. Together the volunteers, who come from a wide variety of Hospital departments, speak Spanish, Portuguese, Greek, French, Italian, Arabic, Chinese, Czech, German, Korean, Polish, Romanian and Yiddish. Three University Hospital nurses know sign language and translate for deaf-mutes.

Beverly A. Ogaldez, a native of Honduras, is coordinator of bilingual services. In addition to directing volunteers and working as chief Spanish translator, Ogaldez translates signs and important written material into Spanish.

During a typical day, Ogaldez may take a medical history in the gynecology clinic, give exercise instructions to a physical-therapy patient, explain special diets to other patients and translate a conversation with a social worker.

Ogaldez, who lived in Spain for two years, emphasizes that she is a translator and not an interpreter. "I translate exactly what the patient or physician says," she explained "I don't add my own interpretation."

When she does not speak a patient's native language, Ogaldez accompanies one of her Hospital colleagues as the volunteer translates.

Ogaldez speaks English, Spanish and Portuguese.

While a patient is in the Hospital, Ogaldez or a volunteer makes bilingual signs for the patient to use in indicating pain or requesting specific items. She also makes signs for nurses to use in communicating with the patient.

Check on services. Members of the
Sometimes "translation service" means more than translating.

bilingual service visit patients during their stay to see how they are doing and ask if they are satisfied with the services. The information is then given to the head nurse.

Before a patient goes home, Ogaldez makes sure that he understands the physician's instructions and how to take any indicated medicine. She also makes follow-up calls on patients after they are discharged.

When Ogaldez knows in advance that a non-English-speaking patient is coming to the Hospital, she or a member of her staff will meet him. If advance word is not received, the department needing translation services calls her.

At University Hospital, according to Beverly Ogaldez, the most common language of non-English-speaking patients is Spanish, followed by Portuguese and Greek.

**Nursing professor is first named to Johnson fellowship**

Marion Isaacs, assistant professor at the School of Nursing, is the first nurse in the nation to receive a Robert Wood Johnson Health Policy Fellowship. One of six Fellows selected nationwide, Isaacs will spend a year, beginning this fall, working with the U.S. Congress on health issues and participating in health policy seminars.

Robert Wood Johnson Fellowships are awarded annually to outstanding mid-career health professionals who are on faculties of health science centers and medical schools. The fellowships are administered by the Institute of Medicine, in cooperation with the American Political Science Association.

Prior to joining the Boston University faculty in 1974, Isaacs spent 10 years working in several health agencies on Manhattan's Lower East Side. She was the assistant director of nursing at Bellevue Hospital Center for three years. A public health nurse, she also served with the Gouverneur Health Services Program, Mobilization for Youth, Neighborhood Council to Combat Poverty, and the Association for the Help of Retarded Children. A resident of Boston, Isaacs maintains a clinical practice at Roxbury Children's Service.
‘Orthodonture’ unorthodox
To the Editor:
We enjoyed reading our copies of Centerscope, as usual. (It’s a) well-designed publication, informative and very readable. But may we submit a bit of constructive criticism regarding the (Winter/1976) article mentioning “orthodonture”? The word does not exist. Your writer was probably thinking of orthodontia, which is passe, due to its commingled Greek and Latin derivatives. The proper expressions are orthodontics, n., and orthodontic, adj. Hope this helps in the future.
Do keep up the good work.
Orthodontically (adv.) yours,
Sheldon Peck, D.D.S.
Harvey Peck, D.D.S.
Newton, Mass., 02161

(A quick check of our dictionaries, both medical and nonmedical, substantiate that we have, indeed, committed a fracture (fractia?) of the English language. Perhaps our Bostonese led us to put the “ure” in place of the “ia”, leading to the gaffe that you noticed in print. – Editor)

Fuchs the teacher recalled by student
To the Editor:
I greatly enjoyed your recent article about Job Fuchs (Winter/1976 Centerscope). It describes him well. At Alumni Day (May 1) I had the pleasure of reseeing him for the first time in 25 years and recalled his excellence as a teacher and his concern for and support of the medical students. Your article does not emphasize this aspect of Dr. Fuchs sufficiently, I believe.
Sincerely yours,
Douglass S. Thompson, M.D.
BUSM ’51
University of Pittsburgh
Dept. of Obstetrics
and Gynecology
Pittsburgh, Pa.

Research in Progress
(Continued from page 6)
anyone trying to eat while soldering.”
She adds, “The most frightening thing about the whole experience was thinking I was a hypochondriac, that maybe I needed a psychiatrist.” She had already made an appointment with a psychiatrist when she went to see Feldman, and if the neurologist had failed to diagnose the trouble, she would have begun psychiatric treatment for her “housewifeitis.”
Sedman laughs ruefully when she adds the following footnote to her story: After her case was written up in the New England Journal, she received a letter from a physician in San Juan. “And do you know what he asked me? He wanted to know the names of some instruction books on leaded glass, and where he could get some kits.”

Lorraine Loviglio

Mrs. Gerald Blakeley Jr., a director of the Boston Circle for Charity, donates the proceeds of the organization’s winter “Snowball” to Marc Straus, M.D., chief of the University Hospital section of Medical Oncology. The donation was used to purchase a device that counts fine particles of radioactive material incorporated into tumor tissue in one minute instead of one hour when done by hand.
UH's Schwartz, Shapiro push for family practice: 'It's the only way to go'

"Family practice is the way to go."

There is a movement at major metropolitan teaching hospitals, long the preserve of specialists, in favor of family practice. At University Hospital, Robert Schwartz, M.D., and Eli Shapiro, M.D., are in the forefront of the family practice movement.

"Family practice is the country's great medical need," said Dr. Schwartz, a family practitioner for more than 30 years. "It is the least expensive way to provide quality medical care."

"In the best position." This sentiment is shared by Dr. Shapiro, who with 35 years' experience in family practice, said, "Family practitioners are in the best position to provide good medical care at the least expense to the patient and the government."

The physicians, long-time friends, are assistant clinical professors of community medicine and medicine at the School of Medicine and associates in medicine in the Department of Internal Medicine at University Hospital. Both teach physical diagnosis and have medical students assigned to them to receive first-hand experience in community medicine. In addition, both work at the Hospital's Allergy and Respiratory Disease Clinic and Schwartz, who is the School's link with the American Academy of Family Practice, teaches a senior-year elective course in family practice.

An indication of the respect the Hospital has for family practice was Schwartz's election to the medical staff executive committee. He is one of three elected members; all others are department heads or key administrators.

Family practitioners attend to the patient's total health needs, needs that are not met completely by top-notch clinical care. By building a relationship with a patient over the years and by visiting the family at home, a family practitioner understands the patient's social, emotional, environmental and financial background.

The family as a unit. "A family doctor is a pretty good internist," Schwartz remarked, "but the difference is that we look at the family as a social and biologic unit."

"We know if an allergy patient lives in a dust trap or if an elderly patient's spouse is able to care for him at home. We don't make diagnoses in the abstract."

The behavioral aspects of the practice of medicine are important to family physicians, Shapiro said. "We know the behavioral aspects of the family over the years," he said, "and I think that's important to care. It also provides continuity, which is important to the patient."

Patients and their families think of the family physician as a family friend, and "someone to turn to for medical advice," Schwartz said.

Both physicians readily admit that they cannot treat every problem a patient may have. "We don't hesitate to call in others for an opinion," Schwartz said, "but we can handle well over 90 percent of the patients we see."

Shapiro likens the role of a family physician to that of a conductor of a symphony orchestra. "He waves his baton and guides the patient through the various movements, infancy, adolescence, mature adulthood and old age." If a family physician meets a problem he cannot handle, Shapiro said, "he points his baton towards a specialist."

Whether a patient goes to a specialist, Shapiro commented, often depends on his or her economic situation. A family physician practicing in a working class neighborhood will take pap smears, or will remove cinders from a patient's eye, while the same procedures in a more affluent community would be performed by a gynecologist and ophthalmologist.

No age limits. There are no age limits in either physician's practice. Both treat infants and the elderly. Schwartz and Shapiro practice what they preach. Schwartz cares for Shapiro's family, which includes six children, and Shapiro treats Schwartz's family, including his mother and mother-in-law. The elder of Schwartz's two sons is a 1967 graduate of the School of Medicine and his daughter, a nurse, works in the University Hospital Trauma Research Center. Shapiro's wife, Barbara and daughter Marilyn are graduates of the College of Liberal Arts.

Schwartz is fellow of the American Academy of Family Physicians and the American Association for the Advancement of Science. Shapiro and Schwartz are charter diplomates of the American Board of Family Physicians.

Susan Gertman
MARRIAGE & The Physician

Four couples discuss conflicting demands of their professional and private lives

IN an era when the institution of marriage appears to have fallen on bad times, and when the decision to marry and raise a family is being scrutinized as never before, Centerscope wondered about physicians' marriages. Are there special problems that beset the married doctor and his or her family? What is it like to be married to a physician in 1976? Or to be a physician, balancing the demands of an exacting profession against the claims of a spouse and children?

In search of answers to such questions, we invited Norman L. Paul, M.D., lecturer on neurology and a psychiatrist with the BUMC Neurology Department, and his wife, Betty Byfield Paul, a psychiatric social worker in a public school system, to moderate a panel on physicians' marriages. The Pauls are authors of A Marital Puzzle: Transgenerational Analysis in Marriage (Norton, 1975). Also participating on the panel were three other married couples:

Helene Baileen, former teacher and now housewife and mother of three, and David Baileen, M.D., a member of the UH medical staff, a clinical instructor in medicine, and an internist in private practice with offices in the Medical Center's Doctors' Office Building;

Babette Stanton, Ph.D., associate director of the University Hospital quality assurance unit and assistant research professor of medicine in the section of health care, and her husband, Richard Goldstein, M.D., an internist in the Department of Medicine at Massachusetts General Hospital;

and Bertha Offenbach, M.D. (BUSM '36), an ophthalmologist in private practice, and her husband, Nathan Fineberg, M.D., (BUSM '30), a semi-retired otolaryngologist and professor emeritus at BUSM, where he was a clinical professor for 34 years.

We asked these people to discuss the kinds of problems they felt were likely to arise in a marriage when one (or both) of the partners is a physician.

In nearly every case, the couples were meeting each other for the first time when they came together for the panel discussion. Nevertheless, there was a sharing of feelings, observations and insights that panelists later said they had found interesting and even valuable (see epilogue, page 23). We think our readers may find those insights interesting and valuable as well.

NORMAN PAUL: One of the common problems that Betty and I see in a group — we co-lead a multiple family group, which has included many physicians over a period of years— is that the physician, more often than not, is inclined to take the spouse for granted. You know: "I'm busy." You come home late, after tendering the expectation that you will
The physician, more often than not, seems to take his spouse for granted. Be home at an earlier time, and it leads to . . . Let's say, Betty: She has been steaming for an hour, two hours, [and is] angry when I come in late, not having been apprised of this before.

Bertha Offenbach: It happens to all of us.

Norman: It's interesting what the consequences of that can be. Let's say she gets angry at me; then I can feel victimized by her anger, because I'm not really aware that I've set it off by having tendered the expectation that I would be home earlier. That begins to make a bit murky this transition from the work day to being with the family.

Betty Paul: We've been married 25 years. When I got married I didn't have a profession. Things went very well for us, till we had children. When we were first married, we were in the service; we had a marvelous time, sort of on a lark. Then Norman came back to be a resident at Mass. Mental Health Center, and I was pregnant, and I think the most difficult time was when we changed roles — when he became a serious physician and I became a housewife and a mother. I stayed home for 10 years, and that was the basis of a lot of conflict. My mother [had] also stayed home, as had my grandmother, and I had no role model for any other kind of woman's role. I can remember to this day when our first child was under one year old, and I spent the whole day rushing around. I couldn't keep house, I didn't know how to take care of a baby, and Norman came home late and the house was a mess and I was exhausted. And the first thing he said to me was, "Well, what have you been doing all day?"

(Laughter) We had a lot of work to do on getting to understand each other.

Nathan Fineberg: I think most problems arise when the children come into play. Prior to having children, Bertha and I had our own professions and our own interests. Our fields were more or less related. So if there were meetings, we both went together. We'd just say, let's go to the Academy meeting in Chicago, Las Vegas, and up we went. And come along our first offspring . . . We were both busy, and it was in our interest and in our son's interest that we have a maid in the house. We could afford it, and we did. In the beginning, we had separate offices. The reason we were not together in the same office was because she had difficulty, as a woman physician — even in my own building — in renting an office.

Betty: Unbelievable.

Nathan: It wasn't easy, you can rest assured. At that time she was treated as a true member of a minority . . . Bertha is very strong. She had to be very strong all the way through life, through medical school and in practice. She had to be strong to get into medical school, to get a place to practice. Of course that carried over to our family life, too; she had to be stronger than I was, because I wasn't built that way. I was a little bit more complaisant . . .

Betty: So, you're saying that one member of a physician's family has to be stronger than the other?

The problems are so difficult that one finds it hard to shift gears

Nathan: Not necessarily. It so happens that if we were both strong, I don't think we could live with one another. If one is strong and has her own ideas (naturally the other has his own ideas, too), the one who is less strong begins to weigh the incident: Is it worth fighting over? Shall he give her the chance to have her way, and
maybe his chance will come some other time? But if both
are strong and both won’t give, then there’s conflict, and
first thing you know, you end up in the divorce court.

Norman: Dave and Helene, you have kids, how does
the presence of children on the scene affect David’s com­
ing into the house and getting adjusted to the [family]?

David Baiien: As our children came along, Helene,
who had been teaching, then stayed at home. I think that
has required certain adjustments. In terms of the chil­
dren, and coming home at night, I find that this is what I
look forward to during the day at work. And one of my
major problems is that, as a physician, the problems you
come up against in your work are inherently not only so
difficult, but so all-encompassing. You’re dealing with
people, dealing with their lives, with their problems, and
I find it somewhat difficult to shift gears when I first
come home. This conflicts very directly with my underly­
ing desire to be able to really share some of this time
with my children. But these concerns that you have —
maybe even just the practical problem of the phone calls
that you still have to answer — interfere with this time
when you come into the home. It’s hard to shift gears so
dramatically, and especially when the last patient of the
day is more or less of an emergency, a patient worked in
at the end of the day because of an acute problem. So
that, although as the day goes by I think of coming home
and look forward to that, I find that when the time
comes, very often you’re really just either emotionally
exhausted or just want to relax for a while.

Norman [To Helene Baille]; And how do you cope
with that when he’s coming through?

Helene: We find we’re not very typical in comparison
with our friends who are physicians. When David comes
in, and, as he says, is in the process of shifting, I get the
benefit of it, because he sits very quietly during dinner,
and he just wants to hear what happened during the
day. As opposed to friends of mine whose husbands are

Left alone with the baby, you realize
you have to have your own interests

Helene: I did teach for two years before we got mar­
rried, and for four years after, and was involved — I
taught French — in taking extra French courses at night.
We were both very, very busy. I became pregnant and
had Laurence when David graduated from medical
school. And the time shifted, because he became an in­
tern, and the medical internship at that time was every
other night and every other weekend. [At those times] I
was alone with the baby. And here I was, I wasn’t teach­
ing French, I wasn’t taking my French courses. I had to
develop something for myself at home, and out of that I
developed an interest in art, became involved in the
Wives’ Club, and started getting very involved in differ­
ent things. When David came home, he always encom­
passed us. If David had to study, it didn’t bother him if I
talked on the phone; he wanted me to talk louder so he
could hear. Or the TV: We have a friend who made his
wife go out and buy a set of earphones to watch TV.
That really wasn’t the case with us, but when David
wasn’t there, there was a whole chunk of time that had
to be filled up. So I filled it up, and all of a sudden, four
years ago, he went into private practice. This changed
our lives immensely, because here I was set in my paint­
ing, and I had started to sell paintings; I was becoming
more and more involved with the wives’ organization,
PTA, things at our synagogue. I was becoming very involved in community life and in my own interests — and then he came home. He had a practice and now he was home every other weekend. And that was a problem: I’d had to build up for seven years a reserve to keep myself busy, and now David was back on the scene. And when he’s on the scene, we all do things together. There were picnics and museums and activities. The first year he was in practice he had Wednesday afternoons off — and I had never seen him during the week, and I had never seen him for a full weekend. So this became an area of my adjusting to him coming back into the fold again, full time.

Betty: You sound as if you can use change creatively.
Helene: Yeah, I do, I have fun.

Being home more, he ‘expected that my wife would be so overjoyed’

David: I was unaware, until this discussion came up, of the change when I went into practice — when I was, in fact, spending more time at home than before — I expected that my wife would be so overjoyed. . . . I was unaware, until thinking about it in this context, that there was a further adjustment for her to make.

Betty: Here we are, intelligent people, and we don’t communicate. I find that, too. We don’t communicate the way we think that “thinking individuals” do, really.

Norman: I think that has to do with not knowing that it’s really that important.

Bertha: When Ed [her son] was a house officer and Judy [his wife] was finishing school, I would call my son at eight o’clock, when I thought they’d be finished with dinner, and I’d say, “How is Ed?” “I don’t know, he’s fast asleep.” And I felt the resentment in her voice. The next year, he had a fellowship, which was a very leisurely kind of thing for him, and she was a house officer. I would call after dinner, and Ed would answer the phone. “And how is Judy?” “I don’t know, she’s asleep.” And I’d feel the resentment in his voice, because she had been working hard all day. And at the same time I heard of their colleagues, the classmates of my son and my daughter-in-law, who were married for two and three years and were being divorced.

Richard Goldstein: When we were dating, I was in the Public Health Service. We actually met working in the same agency. And although we were working fairly hard, and had a fair amount of traveling to do, it wasn’t like being a house officer. Then we got married, and I went out to St. Louis. Babette was supposed to have a job firmly committed within a couple of weeks, and it turned out that the job didn’t come through for seven months. So we started our marriage with Babette coming [from Washington, D.C.] to St. Louis on weekends, thinking that in a couple of weeks the city will finally confirm. . . . I was on an every-third-night rotation, which is easier than every other night, but it’s not a bargain. We hadn’t even been going out when I was in training. And certainly, it’s very different being in training from being in the Public Health Service. Time pressure was a lot greater than it had been when we were dating. We just didn’t have as much time to be together as we were used to. . . . I think another experience everyone has in medical school is that when you’re taking care of sick patients for the first few times, it’s very emotionally draining. You get totally involved in their care and their problems. And one of the lessons you have to begin to learn is how to save some of your own emotional energy.

Norman: Can you save some?
Rick: Well . . . how do you at least try to save some? And how do you do that without ruining the care of the patient? Actually, I think it’s particularly acute when you’re taking care of psychiatric patients. You can be engulfed in their needs.
Betty: That [question of] energy is something I think pertains both to men and women. If I’d known, after our first baby was born, that I had to reserve energy from the baby, and my husband had to reserve energy from psychiatry, we could have saved a little bit each for the other. I don’t think that’s ever made clear. We learned about that as we went through our marriage. I think you [Helene] probably do that, perhaps, intuitively. You didn’t even communicate with him [David] that you had to make the change in your life. Now I’m done with that. I went through that stage differently, even though I went through the same thing, I became very involved in community activities, and then suddenly Norman would have a Wednesday afternoon off. Well, I wasn’t as mature. I would just say, “Gee, I’m sorry, I’ve made my plans.” It was a long time before I could step back from my community work and be with him when he was available.

Some learn going through marriage to save some energy for one another

David: I think it’s hard to find the line in dividing your energies. You know, as students, especially at the fourth-year medical student and intern level, you’re training to devote very meticulous attention to very small details — things like blood tests — and you find yourself caught up in that learning. Remember that physicians, especially in medicine and surgery, are taught with very sick patients first in the acute hospital setting, and only later do they branch out into the well patients, or not so sick patients. I think, as Rick said, you find the care of a very sick patient, or particularly a patient who has emotional problems, can become all-encompassing. I think I’ve found it difficult to reserve some of this energy. We’re not really taught how to reserve energy.

Norman: Or even to think about it.

Nathan: A very important aspect in the life of a married couple, whether they’re physicians or nonphysicians, is what you said, Helene, regarding painting and interests in community affairs. I think one should have a hobby of some kind. I think if you’re involved too much in any one thing it becomes a little bit boring. Many, many years ago I started a hobby, and Bertha started a hobby. She got engrossed with her painting, collage, and I got engrossed with my sculpture. There’s always an opportunity to get away from the whole family life for the moment, for half a day, and come back renewed and refreshed. I think that it’s good medicine to have something in mind other than sick patients all the time. So, I always try to do my best for my patient, but once I’m through, I like to go home, relax and forget about it. I can always break away and go down to my studio or, in Gloucester where we summer, I can get lost in my outdoor studio. I work outdoors, chipping away. It completes the person as a whole if you have something other than your own profession to do.

Bertha: Is there any merit in asking, in a course that you may be planning for a medical student, to say, Now look, let’s be objective about this, find out the kind of a person who would make a good partner for a physician. Is that possible? To remove the evanescent thing that is romance and the attraction that comes from chemistry, electricity, or whatever it is that we call love, and look at the thing in a cold, calculating light, and say, “Now, what is the kind of person a medical student or a doctor should have as a partner?”

Norman: Babette, were you ever calculating? Did you

*Earlier, Dr. Paul had said he had given considerable thought to giving a seminar for first-year medical students and their spouses or fiancées on the theme of physicians and marriage.
ever think of the kind of person you would like?
Babette Stanton: I'm not sure. I knew what I was getting into.

Norman: What did you think you were getting into?
Babette: I think I had a very realistic idea of what I was getting into. There may be components of it that I wasn't prepared for; for instance, when we got married and right after the honeymoon Rick goes to St. Louis and I'm commuting for seven months. Then I finally go out there and I get this wonderful, great job, which is a total shift of all gears; start in a totally different city, get all involved, get some research going, try to reorganize my whole system and, whoomp! July 1 comes and we're going to Boston. Go to Boston, start something else.

There's this funny feeling: Is there a sense of permanency in any one place, even if you shift gears, start all over, get involved in and interested in something new? I didn't expect perhaps as many moves as quickly or at such small intervals, like five months. Now that's a little too much. So other than that, basically what I've gotten into, I've certainly expected. I think our problem is a little different from, or our perspective on the timing thing is a little different from, Helene's and Dave's and yours [the Pauls'] in that we do feel very pressured for time. We have very little time. We both get home very late in the evening.

'We feel very pressured for time; we have very little time'

Norman: When you say late, you mean what hour?
Babette: About nine o'clock, ten o'clock, eight thirty. I never know what time I'm going to serve dinner any night of the week, and I don't even worry about it. We'll eat whenever Rick comes home, plus however many more minutes it takes to get the roast beef up to 350 degrees again and the baked potatoes back up, the lamb chops browned one more time, or whatever. But basically we start every evening with finding out where we are.

We don't start by tuning out or relaxing. We always start by asking each other how was our day, and then we go through all the things that happened that are important in the day. We get everything else out first, so that we know where each of us is when we're starting. And then there's very little left of the evening by the time I've done the dishes. And I go off and read my journals, and he goes off and reads his. And then we watch the news, and that's the evening. Or some evenings we'll talk. It's less frequent that we would go to a play together or a museum, even though we love those things. I think there's some sense of loss that we have very few social activities. We've escaped to the Cape on weekends, and that's very relaxing.

Norman: ... but not much interaction with other people.
Babette: ... You look back and you say, "Gee, what have we done in the last three months?" We practically haven't done any of the things we've been looking forward to coming back to Boston for, and that's something we are still dissatisfied about and haven't really worked through. How are we going to set aside some time so that we do some of those things we want to? ... I mean, things like concert series. We can't subscribe because we never know which nights he'll be on call.

Norman: But were you suggesting an important vein that a lot of physicians feel, and that is the sense of feeling controlled by the profession, that your life is sort of dictated by what is happening where you're working and that you don't really have that much control over it?
Rick: Well, that, and you're trying to do a certain amount of journal reading, and the other things you like to read — current events, novels — those become fewer and fewer.
Babette: Two Sundays ago, Rick was working all day, and I actually went out, and — this is something I haven't done in so long, I actually felt guilty — I went down to the drug store and I bought, not only the New York Times, but the Boston Globe and two magazines. I spent the whole day.

Norman: ... with magazines? (Laughter)
Babette: I hid the Atlantic Monthly. (Laughter) No, generally I finish all the journals that came in that week on Sunday. But, actually, it's funny, you can almost feel guilty when you're doing something that you really enjoy if you spend a whole day doing it.

Betty: What you [Norman] said about the profession controlling our lives, I really think that's a very important point. I know it was many, many years before we could get to the point where we could take a whole weekend or once a month, and do something that had nothing to do with medicine.

Babette: Or do nothing.
Helene: That's what I miss — doing nothing.
Norman: What is this "doing nothing"? (Laughter)
Helene: It's sitting home and going through all the old magazines....
Norman: That's not doing nothing, that's doing something. It's going through all the old magazines.
Bertha: Leisure.
Norman: Bona fide, real leisure.
David: Bona fide, real leisure.

David: I think that when you do have time available and you're not completely exhausted — for example, on Wednesdays — you're really anxious to do something outside of medicine, and yet you do have all of these constraints and turn to journal reading and that type of thing and you have piles, oh, unbelievable...

Helene: Our house is sinking. It looks like Venice.
David: ... that you want to go through, so I think very much so, even in the most relaxed type of medical practice....
Norman: Where's that? (Laughter)
David: ... I don't know where that is, but if it exists, there are still many more constraints than there are in most other fields, I think. In terms of actual hours put in, there are probably many other occupations — certainly people in retail stores and things like that — who actually put in as many hours and, yet, still don't have as many constraints on them as the medical profession and practice places on you.

Rick: I'm not real sure of that. My brother-in-law's in real estate development and works very, very hard. His time commitment is probably just about...

David: That's what I mean. His time commitment is
high, but he still doesn't have the bounds in terms of being on call certain times in the day, certain times of the night, certainly.

Rick: ... he's on call. He's the executive vice president of the company. He's on call to the president of the company anytime — even when he's on vacation.

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**A particular kind of person with an enlarged conscience**

Bertha: The type of individual who goes into medicine is a particular kind of person with an enlarged conscience and a great sense of guilt about making his patients comfortable and healing them. Nathan can fall asleep after he has taken care of a sick person, done everything he can for her. But I think many of us go to bed thinking about our patients and worrying about them. I do more than he does — and not only go to sleep thinking about patients, but about my children, and about him, and about the world around me. The problems just overwhelm me, and it's my particular kind of makeup, my particular kind of personality. There are more of my kind of person in medicine, I think.

Centerscope: I was intrigued by your question earlier, Dr. Offenbach, when you asked whether medical students could be taught to look for certain characteristics in a spouse. It sounded as if you had some in mind.

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**'It isn't such a bad idea for parents to pick the spouse'**

Bertha: When I was first in practice, the first woman doctor from Afghanistan was a guest at our house. My children were appalled that this 21-year-old girl was going back to Afghanistan, because her parents had picked a spouse for her. She accepted it as the thing to do. These very same teenagers, who were appalled, told me very recently (my son is 35 and my daughter is 33) that it isn't such a bad idea when parents choose the spouse of their child. [Parents] know their tastes, they know the social class they should come from, they know what their child needs and they do not pick someone who isn't appropriate...

Betty: I would think rather than having a course in which one became involved with what one would look for in a spouse, I think the purpose would be to become more self-aware, to find out what kind of person one really was oneself. If you're very self-aware, you can begin to know what kind of a partner would satisfy you.

Rick: I think if you've been going out with someone for a fair amount of time, a certain amount of rationality is bound to seep in.

Centerscope: We wanted to be sure to have a woman physician on this panel, and we had a certain amount of difficulty, because some of the people we called said, 'I can't tell you anyone, because most of the women physicians I know are divorced.'

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**'I think happiness and misery are contagious'**

Bertha: But most of the women physicians I know and am intimate with and like are married. And one thing I do in my life consciously, and I tell my children and other young people, is stay away from the people who are not happy. I think happiness and misery are contagious, and I stay away from the spouses who are fighting and nagging at each other.

Helene: That's so hard to do. Frankly, in our age group, we're surrounded by people who are good friends, people that we've been friendly with since before their marriages, who are going through separations. In my son's elementary school last year, out of 22 children, six pairs of parents were in the process of divorce, and of the six [sets of] parents five of them included physicians. Radiologists, obstetricians...

Betty: I've been working in the same school system for 10 years. When I first got there, divorce was unknown. This was a largely Catholic community. I would say that a quarter of every classroom's children have divorced parents, and then it's not necessarily physicians.

Bertha: Why is it happening? What's taking place?

Norman: I think people want too much of one another in a marriage. We used to have much more emotional back-up in terms of extended family. The demands that each spouse places on the other, including myself, are extraordinarily higher now than they used to be. I think a lot of people have a notion — and I think TV has something to do with it — of the Dick Van Dyke Show as the idealized kind of marriage. So that some couples, and these are intelligent people, feel that their marriages do not come up to that standard, meaning that they're a failure.

Rick: I think the break-up of the extended family is important. I can remember when I was young, all my mother's family were in the same city. On weekends we frequently would go to one house or another, and they were a safety belt. I mean, you had uncles, grandparents; there were other older models and other people around to help out. My sister and brother are out in Detroit, and we're here, and there isn't any of that. I think that sacrifices a lot, and I think especially when there are children. For example, when my father was in the service during the war, my grandfather lived with us. As I think back about it, he essentially played the father role. He was there to do that, and now so many times there is no family there.

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**'It isn't such a bad idea for parents to pick the spouse'**

Nathan: That brings up a point... If the children are brought up in a stable home life, the chances of divorce when they get married would be, to my way of thinking, less.

Norman: I was thinking about what you were talking about, Rick, in terms of extended family and what the pressures are now. I think that because of the absence of extended family now, the need for dialogue is even greater. During the past, you could get away without it.

David: Possibly the Feinbergs, both being physicians,
were very attuned to this problem. Things were successful and, possibly in some medical marriages, when just one of the spouses is a physician, possibly they're not attuned to this. The physician parent thinks that the other parent will be compensating for any of the loss — in time, pressures, or what have you — that the physician causes in the family. Possibly the spouse would have to be someone who could compensate or bend. This is probably true for marriage in general, that the spouse has to be someone who can adapt. In medicine, you have to adapt a little bit more than in other areas, but the more I see, the more it seems to me as though these are more general problems, rather than problems specific to physicians.

Norman: What do you mean by "compensate"?

Possibly the other parent may have to compensate

David: Well, if the physician parent is kept away from the home, either by his own responsibilities or by a certain involvement in the constraints of his practice — even if he's there in body, he has a stack of journals that he wants to read, that he has to get through — possibly the other parent may, in a sense, have to compensate for some of this. I don’t know if they can.

Norman: I don’t think, in the long run, one person can compensate for another. I think that it’s desirable for each parent to have his or her own relationship with the child, uncontaminated by the bias of the other parent. Generally, what’s most important in the parent-child relationship is the quality of the relationship. Five minutes of meaningful dialogue exchanged between the parent and the child is worth more than a year of spending time with the child and not having any dialogue.

Helene: There seems to be a feeling of guilt on the part of some physicians that because their field is so time-consuming, any time to spare has got to be spent doing things to make up for the time that isn't there. When our oldest was in nursery school, the teacher said, “It’s obvious that there’s an awful lot of time and effort put in on both of your parts. When does your husband ever have time?” And, what David was doing was, when our oldest was an early riser, at 5:30 in the morning they were building blocks before he went off to school. Whereas another parent who was perhaps not in this field, wouldn’t have this feeling that his time is so taken up, and would still maybe wake up at 5:30 in the morning, but play solitaire or something.

David: To finish the story, our younger one is just the opposite. He gets up very late, but he won’t go to sleep at night, so we end up having time together after his older brother goes to bed, every night at 7:30.

Helene: About what Rick said before about not having the time to go to the symphony. Somehow, there seems to be a more exerted, strong effort on David's part not to miss a concert or a symphony or a play when he is home on the weekends.

David: You really have to squeeze things in. I think — do things very spontaneously. You can’t buy symphony tickets three weeks in advance, or else you’re going to be invariably disappointed. But if you find that you have time free and you can go, then you go.

Nathan: You have to find time to devote to the children, and I was always conscious of that. I made it my business to play with my boy, because I enjoyed playing with him. Whether it was baseball, tennis later on, or wrestling, or throwing me in the closet and closing the door or vice versa (Laughter) . . . We had a lot of fun together and I think it pays off.

Babette: Rick and I are at a point in our lives where we’re seeing a lot of physicians — relatives and friends — who are retiring. It’s an amazing phenomenon to watch a physician retire. It’s a very painful phenomenon. And, as I listen to Helene with the painting and everything, what we’re trying to do right now is to build up a whole lot of things. It won’t be as if we’re retiring from one thing and starting a new thing, because that wouldn’t be an adequate substitute. We’re trying to do some things now and develop some abilities, so that later it will be something that continues when something else ends rather than [beginning] something new.

Nathan: I agree with you there, because you build up your outside interests slowly, but when you reach the point of retirement, you don’t retire, close up your office, and say I’m through. You cut down, but you can devote more time to your other interests, so that when you get to the point: “It’s time for me to retire,” then you are full time without breaking up or allowing any monotony to enter into the project.

Babette: But don’t you think that for physicians and, perhaps, politicians, retiring is something they really react violently to?

Betty: Well, I think that’s true of everybody.

Watching a physician retire is ‘an amazing phenomenon’

Helene: I think about [retirement] because I see parents of friends, and my own mother, who are at an age now where they can’t work anymore. They’re retired, but they haven’t developed these other interests to make their retirement worthwhile. I see lives that could be so creative. It bothers me no end to see these people who are not doing anything.

Centerscope: This note of retirement might be a good place to stop.

Bertha: What did we say that meant anything?

Norman: I think we said a lot of things that are important. Primarily, that in sharing our experiences, we’re really neutralizing a lot of the myths that people have about the perfectability of, let’s say, a physician’s marriage. There’s nothing that really is perfect. We all live in the kind of process that includes changes and stresses. How we cope with them is the real issue.

Betty: I heard that — although it seems to me the people here have an unusual degree of self-sufficiency — I still learned that, generally speaking, it was the wives [here] that made the adjustment. In your [Bertha’s] case you moved your office to the home, and in your
[Helene’s] case you changed your schedule to meet his, and in your [Babette’s] case you moved to be with him. You know, although we as women can each have our professions or our artistic pursuits, essentially our role is to, has been to, do a little bit more of the changing than the man.

Norman: That hasn’t changed, over the years.
Helene: Is it beginning to change now, with the climate the way it is?

‘It was the wives here that made the adjustment’

Betty: Maybe that’s a point. I think that maybe young women’s expectations are all unrealistic, if they think that we can be the same as men. Perhaps we’re beginning to be more equal, but I still do not think we’re the same. I’m just as glad, but I think part of the non-sameness involves one of the couple perhaps having to adjust more. I notice that you [David] were the one who said, when we were talking about compensation, there were journals you had to read, but she would compensate. I’m not criticizing, I think that’s very realistic, but it was her compensation you were talking about. . . . I’m saying that mothers are mothers. That’s an occupation in itself, and I think it should be recognized formally. It’s sort of short-lived, but it’s a career, and I consider it a very serious and important career, whether you’re a physician or not.

Bertha: That’s true, but as you say, it occupies a certain part of our life, and we can’t close it off entirely before or after. We can, in a general sense, plan for these spaces.

Nathan: In summary, I would say that we’ve been married 35 years — [to Bertha] would you say? (Laughter)
Bertha: We have a 40-year contract.
Norman: What’s going to happen in 40 years?
Nathan: We don’t know, but so far so good, and I think the whole thing can be summarized as a matter of stability. Do you want to make a thing go, or do you want to keep fighting with one another, or do you want to make compromises? This is a marriage, regardless of whether the spouse is a physician or nonphysician. It’s a matter of combining ideas and thoughts for the better of your family, for the mutual benefit. And when I see all the divorces and all the changes taking place, I look at Bertha, and I say, Well, we didn’t do too badly; let’s continue.

Centerscope: Thank you all very much.

Epilogue

Several weeks after the event, panelists expressed varying reactions to the experience of participating in Centerscope’s panel. Babette Stanton’s response was perhaps the most positive: “Listening to the Bailens, it just hit us that we don’t take enough time to enjoy some of the things that are purely just fun. We are always working toward a goal that’s work-related . . . . Things have changed a bit [since the panel]. We’ve been going to more plays and reading more things not related to medicine . . . . We’ve succeeded to some extent in making more time for ourselves and it’s been fun.”

Rick Goldstein agreed that “finding time for ourselves” seemed to be an issue for the two younger couples, but added, “Internal medicine is very different from ENT and ophthalmology. If I’m on call, I don’t have the ability to cut things off at 5 o’clock.”

“It was so revealing,” said Bertha Offenbach. “In a group, or talking to a third party, we reveal certain thoughts we don’t reveal to our partners.”

Nathan Fineberg pointed out that his reaction to the panel was bound to be different from those of the younger participants. “We’re old-timers,” he said of himself and his wife. “We went through the gamut of problems over the years.”

David Bailen found the panel a “means of gaining more insight and understanding of our own relationships with our spouses. In our case, for example, my wife had been making certain adjustments to my being a house officer and then going into private practice, and this had never been verbalized before.”

Helene Bailen said, “David and I started to talk about things we really hadn’t thought about before, such as his having to shift gears when he comes home in the evening.” The panel experience “opened up new avenues of communication for us”, she said.

Lorraine Loviglio
Earthquake in Guatemala
by Lorraine Loviglio

MAUREEN Strafford woke up at 3 a.m. in her apartment in Antigua, Guatemala, and became aware simultaneously of several peculiar facts: outside, dogs were howling wildly; inside, lamps and other furnishings were crashing to the floor; and her bed was skidding around the room.

A common occurrence? Maureen, a BUSM fourth-year student, had only been in Guatemala for three days, and one of her thoughts in those first confused moments after waking was, “Maybe this sort of thing happens all the time here.”

It doesn’t. Maureen Strafford had arrived in Guatemala to fulfill her month-long Community Medicine elective at a public-health clinic in the town of Chimaltenango just in time to experience one of the most devastating natural disasters of the century — the February 4th earthquake that killed 25,000 persons, injured 70,000, and left more than a million — almost one-fifth of the population — homeless.

In the next 10 days, Maureen would see more broken bones, crushed bodies and severe lacerations than most physicians see in an entire career. She would sew up hundreds of gaping wounds, many without anesthesia, and would witness countless instances of amazing courage and dignity in the midst of intense suffering among the largely Indian population of the region.

But in those first minutes of the earthquake, Maureen could only think about dressing quickly, grabbing her passport and money, and rushing outside, away from the threatened walls of her apartment building. There she joined three other medical students, all from Columbia University, with whom she was going to be working at the public health clinic in Chimaltenango.

“There was a roaring sound that seemed to go on for a long time,” Maureen remembers. “I don’t think we realized the extent of the damage until we got to the center of town. It was crowded, and there was a church and it was just as if giant boulders had fallen off into the streets. And when we saw the parts of town where there were many adobe buildings, we knew there would be people who had been killed. There were people buried and there were others trying to dig them out.”

Adobe dwellings crumble. While many modern buildings had held up reasonably well, Maureen explained, the adobe dwellings of much of the Indian population of Antigua and the outlying towns were without support and crumbled completely in the quake. To make matters worse, most of the adobe houses have corrugated metal roofs, and when the walls collapsed, the metal roofs fell on the occupants, causing the cruel lacerations that Maureen and other medical personnel would see in such large numbers among their patients.

Maureen continues her story: “When we saw all the injured, we decided we should go over to the clinic in Chimaltenango. One of the medical students had a car, but we found we couldn’t get through the roads because of the landslides. So we returned to the hospital in Antigua until daybreak, and then tried again. It took hours, trying different routes, [Chimaltenango is about seven miles from Antigua], but we eventually did get there.”

Even after all the damage they had seen in Antigua and along the road, the medical students were shocked by the scene that greeted them when they drove into Chimaltenango. The town had been reduced to a heap of rubble, “it looked like someone had dropped a bomb over Chimaltenango,” Maureen recalls.

Some 15 or 20 years ago — Maureen isn’t sure how many — an American doctor from Kansas named Behrhorst had gone to Chimaltenango to set up a clinic for the Indians there. Not only had he taken the trouble at that time to go to each Indian village and town to explain to the people that his clinic had been established to attend to their medical needs, but he had continued to provide medical care to all who came to the clinic, while respecting the ways of the people. It is the custom among the Indians of Guatemala, for example, when someone is sick, for the entire family to bring the patient to the clinic and then remain to cook for him and look after his non-medical needs. And when family members deduce a patient is dying, it is not uncommon for them to take him home from the clinic to die.

Lorraine Loviglio is a Centerscope staff writer.
Doctor Behrhorst had respected these customs, and now, all through the earthquake and its aftermath, the Indians showed their trust by flocking to his clinic by the hundreds.

**Start triaging!** The patients were lying on the ground, and there were just hundreds of people lying there, and they were still carrying them in," Maureen says. "Someone shouted at us, 'Start triaging!' We knew we were going to be short of supplies, so we were triaging them into those who were dying, over in one corner; people who had fractures, in another corner; people who had lacerations to be sewn up, and the people who weren't too bad.

"Every patient was given a little folder, and we wrote their name, their age, what village they came from, and what we diagnosed their problem to be. And then, whatever medications were given were recorded on this sheet, you know, because that was going to be our only record."

The injuries were "all trauma," crush injuries and lacerations. "We knew we had to sew people up as soon as possible because there was no electricity, and you were going to be doing it under candles pretty soon. And we couldn't take x-rays, so later in the day we went around and cast some splints on people. But some of them had compound fractures, where the bone sort of sticks out of the skin. I saw things I'm sure I'll never see again."

**Dignity and stoicism recalled.** Most impressive to Maureen was the dignity and stoicism with which the Indians bore their injuries, and their tenderness to each other. She remembers a man whose forehead was badly cut, and whose eyelid was nearly severed and had to be sewed back on. "We knew it was just incredibly painful, and his whole face had just sort of blown up. His friends stood by him, while we sewed the eyelid, and kept wiping the sweat off his face and telling him not to worry."

"There was this very old man who was paralyzed from the waist down — there were a lot of spinal cord sections — and his wife, who was just as old, was taking care of him. I told her I was going to give him an injection for pain, and that she should make him drink as much liquid as possible. She said 'Can I have one of your pills?' I said, 'Of course. Do you have pain anywhere?' And she pulled up her skirt and showed me a bone sticking out of her leg."

If the bravery of the patients was inspiring to the young medical student, the lack of basic equipment to help them was terribly frustrating. Maureen had seen trauma before, during her surgery training at Boston City Hospital's emergency room, where gunshot wounds and stabbings are frequently treated. But here in Chimaltenango there were no facilities for doing surgery, for example. "A lot of the things we were seeing were surgical cases, such as people whose feet were practically cut off. You sewed them back up as best you could, knowing that what they really needed was an amputation. We were sewing people up without anesthetic. We didn't even have gloves, after a while... A lot of people had internal injuries and they get a peritonitis from it. You'd see these stiff-as-a-board abdomens, but there was nothing you could do."

**No blood, little demerol.** There was no blood to give people in shock, and after the limited supplies of demerol gave out in the first few hours, the only pain medication was a codeine-aspirin mixture, only slightly stronger than aspirin.

Besides Maureen and the three Columbia medical students, there were two doctors working on the injured, several nurses, and a group of about a dozen American college students, who had come to Guatemala with the Experiment in International Living. The students had spent the night digging people out of the rubble, and then had come to the clinic to help. "We taught them to do injections. They ended up doing just about everything," Maureen says. "They were simply fantastic."

Later, trucks began to arrive from Guatemala City to transport the most seriously injured back there for surgery, and here the stoicism of the Guatemalans created difficulties. Maureen explains: "We had to go around and decide who deserved to go on the truck first. But you couldn't make the decision based on which people were moaning and groaning, because people were not moaning and groaning. So you had to constantly go back and review all the patients, to know who to send."

**Help for those alone.** Not only did families stay together to care for their injured members, but as Maureen later learned, they also took care of people who were alone. One little boy, scheduled to be taken to Guatemala City for surgery, turned out to have no relatives left, his entire family having been wiped out by the earthquake. The family of the patient next to him, who had been looking after the boy, told Maureen, "Tell the doctors our name, and we'll take care of him."

Later in the week, the U.S. Army set up a 100-bed hospital, equipped for surgery, close to the Behrhorst Clinic, thus easing the situation considerably.

Of the lasting effects of her experience in Chimaltenango, Maureen says: "I grew up seeing death and destruction on TV. I don't think I'll ever see it the same way again. When I used to hear about 10,000 dead somewhere, I didn't know what that meant. I have a sense of what that means now."

The experience also gave her a sense of perspective. Maureen feels, and changed her priorities. "I mean, how bad can an internship be after an earthquake?" she asks wryly. More seriously, the experience of being suddenly plunged into a medical emergency on such a scale, far from causing her and her fellow medical students to feel inadequate, strengthened their confidence in themselves and their medical abilities.

"The whole thing made me realize how important my medical skills really were. I discovered I didn't have a skill I could use to help people. You know, medical students sometimes feel a lack of self-confidence. But, by the time we were through in Chimaltenango, we felt very confident. You had to. Under those conditions, the best orthopedic surgeon in the world couldn't have done any better."

Maureen feels, and changed her priorities. "I mean, how bad can an internship be after an earthquake?" she asks wryly. More seriously, the experience of being suddenly plunged into a medical emergency on such a scale, far from causing her and her fellow medical students to feel inadequate, strengthened their confidence in themselves and their medical abilities.
UH Institute for Correction of Facial Deformities draws its strength from diversity

Artist's sketches show the surgical procedure to correct prognathism, a jutting lower jaw. As the arrows in the top photo indicate, the surgeon moves the lower jaw back to align it with the upper jaw and the rest of the face. The bottom photo shows the profile after corrective surgery.

by Susan Gertman

ALMOST since birth, Peter Brown has had to cope with curious stares from strangers and taunts from school children because of facial abnormalities and extremely nasal speech associated with cleft palate and lip.

This summer, however, after his second operation at the Institute for Correction of Facial Deformities at University Hospital, Peter (not his real name) will not have to live with stares and jibes anymore. A team of surgeons will harvest a bone graft from Peter's hip and fill in the cleft between the two halves of his upper jaw. During his first operation at University Hospital, the Institute's surgeons moved Peter's underdeveloped jaw forward, thus putting it in proper alignment with the rest of his face.

Second operation. The second operation will cap more than two years of treatment at the Institute for the Correction of Facial Deformities, a New England regional center that provides a multi-disciplinary approach to the correction and management of cranio-facial abnormalities. Peter's treatment includes complete physical examinations, dentistry, orthodontics, speech therapy, oral and plastic surgery and counseling sessions with a social worker for himself and his family.

The head and face are complex structures that include the preserves of oral and plastic surgeons, dentists and specialists in dentistry, neurologists, ophthalmologists, and otolaryngologists (ear, nose and throat specialists).

"Since deformities of the head and neck go across specialty lines, one professional cannot give total treatment," said Donald F. Booth, D.M.D., co-director of the Institute and chief of the Department of Oral Surgery and Stomatology at University Hospital. Dr. Booth is also the chairman of the Department of Oral Surgery at the School of Graduate Dentistry.

The Institute, which recently received a major grant from a private philanthropic foundation, treats patients with congenital, developmental and acquired deformities and hopes to expand its services by treating deformities caused by the removal of a tumor.

'Acceptability' the goal. "We are not trying to create beauties — we are trying to create acceptability," said Gaspar W. Anastasi, M.D., co-director of the institute and chief of plastic surgery at University Hospital.

Booth and Anastasi cite numerous examples of youngsters of normal intelligence who are sent to institutions for the retarded because they have severe cranio-facial (head and face) deformities. "Often these children cannot speak clearly because their palates are not functioning; they have repeated ear infections and cannot hear well; their faces are deformed and they drool; so people think they are retarded when what they have is a communication problem caused by a structural anomaly," Anastasi said.

Treatment at the Institute not only corrects structural and functional problems, but also produces marked changes in the patient's interpersonal relationships. "We see personality changes all the time," Booth said, "The patient is a totally different person; there is a total change in his environment."

Most common problem. Cleft palate and lip are the most common of the congenital cranio-facial abnormalities, occurring about once in 770 births. A cleft palate is an abnormal opening in the roof of the mouth caused by the failure of the bones in the upper jaw to fuse in prenatal development. Cleft lip is an opening in the lip caused by a similar failure in fusion. Persons with cleft palate may have teeth growing down the palate instead of through the gums; food and fluid may regurgitate in their noses and they usually have extremely nasal speech.

Children born with cleft palate have to undergo several operations and years of treatment before the abnormality and its effects are corrected.

Peter Brown, the only one of six children in his family born with a facial deformity, was operated on to close his (Continued on page 29)
Serving health-care needs on Alaska's North Slope

by Diane Simmons

In her first morning as clinical director of the 14-bed Alaska Native Health Service Hospital in Barrow, Jerilynn Prior, M.D., treated a man who had eight stab wounds. During the next 10 days she was faced with eight such emergency cases, all of them air-evacuated from Alaska's northernmost town to the hospital in Fairbanks. When the emergency arose after midnight, the problem was intensified for both patient and attendant if, as was sometimes the case, the only pilot in town had spent the evening with a bottle of whiskey.

As one of two doctors serving the Eskimo population of Alaska's North Slope, Dr. Prior, a 1969 graduate of the School of Medicine, dealt with "one tragedy after another." During her stay in Barrow, whose population is approximately 3,000, there were at least ten deaths due to trauma or crime. The deaths, resulting from fights, snowmachine or automobile crashes or gun and knife wounds, were almost all alcohol-related.

The drinking and violence are explained to some extent by the rapid changes occurring on the barren Arctic Ocean coast, Dr. Prior says. Historically ignored by all but Eskimo hunters and fishermen, the North Slope is now the site of oil exploration and drilling. Not too far from Barrow is the mouth of the 900-mile trans-Alaska pipeline.

Not an "easy" year. Her year at Barrow wasn't an easy one, Dr. Prior admits. Besides the long hours and a doctor-patient ratio of approximately one to 1,500 there was the long night of Alaskan winter to be endured, as well as the shortage of fresh supplies. Dr. Prior and her husband, Jim, a graduate student in geography, satisfied a craving for fresh vegetables by growing bean sprouts under grow lights.

In contrast to the difficulties of life in the Arctic was the "excitement of being part of a village that's becoming aware of its cultural identity." And Prior was impressed with the efforts being made by the North Slope Borough governing body to build homes and find new villages. Particularly memorable was a week-long period of feasting, dancing and games at New Year's. Everyone was invited to join, said Prior, who not only joined in, but won a fingertip push-up event for married women.

Working for the Alaska Native Health Service (ANHS) has its rewards. In general, Dr. Prior says, "the preventive care given to native children in Alaskan villages is as good as the care given upper-class children anywhere."

Lack of money, not concern. There are "definite health-care needs," among Alaska's native population, says Prior, now one of two doctors at the ANHS clinic in Fairbanks. But the problem is one of funding rather than lack of concern. The health-care providers in Alaska "are a group with very high morale," Prior says, noting that the situation has improved in recent years. Not only Alaska's natives, but all Alaskans are "under-serviced" in the field of health delivery, she adds.

Prior, a board-certified internist, is no newcomer to Alaska. She grew up in Southwestern Alaska, hitching a ride on a crab boat from her home in Ouzinkie to the high school in Kodiak. Her father is a minister, and her mother serves as one of Alaska's community health workers.
aides, the grass-roots providers for the comprehensive health program Prior now serves.

Still, more than 900 miles of mountains and tundra separate Dr. Prior's home on Larsen Bay from the Arctic seacoast town of Barrow, and the Eskimo culture is different from the Aleut-Russian culture of Southwestern Alaska.

Lost in a 'whiteout'. One of Prior's most vivid memories of Barrow is of a frightening plane ride to a village called Nuiqsut, which had only been founded a year before her arrival in Barrow by Eskimos who wanted to return to ancestral camps. More than 100 people had "moved out across the tundra with their belongings on sleds and snowmachines." (The first year the people lived in canvas tents, but by the second year buildings had been constructed. One of the buildings, set on pilings to protect the fragile permafrost from melting, was a clinic.)

Along with a public-health nurse, a dentist, a dental assistant and a plane load of villagers' supplies including cases of Coca Cola, Dr. Prior flew out from Barrow to hold a three-day clinic at the new village.

The plane was lost for a time in the minus-50 degree Arctic "whiteout" — a condition under which the ground and sky look the same. Then the plane's door flew open and "for one horrible moment" Prior thought a six-year-old who had been playing in the back of the plane had blown out. The child was safe, but the copilot had to hold the door shut for the rest of the flight.

Finally, the pilot spotted the village; the airstrip, built on a frozen lake, was marked by the headlights of snowmachines. Just as the plane was landing, Dr. Prior remembers, somebody drove across the runway on a snowmachine. "The plane pulled up, quivered, and almost didn't make it."

Success in the end. The field trip ended in success. Dr. Prior and company gave complete physicals to 60 or 70 children, seeing 120 people in all. The dentist and his assistant set up a compressor and treated patients in the light of a lamp balanced on a five-gallon kerosene drum. "All you really need," says Dr. Prior, "is a place to lay the patient down and a light. Sometimes a kerosene space heater helps, too."

While the alcohol-related accidents and field trips to villages were frequent, problems caused by poor sanitation were continual. Living conditions in Barrow are extremely crowded, says Prior; the water supply is melted ice chopped out of a lake or hosed up from the bottom.

At most homes, the household "honey bucket" — the Alaskan equivalent of a chamber pot — is emptied into an oil drum in the front yard to be picked up and dumped in the spring. In late winter when the supply of oil drums runs short, the buckets are dumped into plastic bags. The contents immediately freeze and are out of the way until the late spring "breakup." But in May, says Dr. Prior, "the town is a cesspool, and the problems are terrible."

Almost every cut becomes infected, diarrhea persists, and there is an ongoing hepatitis epidemic.

Other persistent problems include upper- and lower-respiratory ailments, ear problems and ordinary colds that turn into bronchitis. And always there are cases of hypothermia, usually the result of mixing alcohol with Arctic temperatures.

Throat cultures taken. As one form of preventive treatment, the Barrow doctors attempted to take throat cultures from everyone having a cold. Streptococcal sore throats were treated with antibiotics to prevent the illness from developing into acute rheumatic fever or glomerulonephritis. The throat culture can be done more effectively in Fairbanks than in Barrow, because of better laboratory support, Prior says.

Other preventive measures included pap tests, accompanied by tests for gonorrhea, an always-prevalent illness that is even more widespread since the beginning of the pipeline work.

Prior also made an effort to examine older people who hadn't had a complete physical exam in years and had only seen a doctor when they had an acute problem.

One potent contribution in the area of prevention came about when the community, responding to a hospital staff meeting on alcohol abuse, voted to close the liquor store and to prohibit the sale of liquor.

The Barrow hospital is one of seven service units of the Alaska Native Health Service, an arm of the U.S. Public Health Service. The Fairbanks clinic where Dr. Prior now works is part of the Tanana Service unit, which has a total of five doctors: two in Fairbanks and three in the ANHS 20-bed hospital in Tanana. A clinic in Fort Yukon has a nurse practitioner, while the remaining villages in the service district are staffed by village health aides who maintain radio contact with either Fairbanks or Tanana.

Trained health aides. The health aides are villagers, usually women selected by the village council to attend a specialized series of courses offered in Anchorage under the Public Health Service Community Health Aide Program. The aides, who are paid by one of several nonprofit native corporations, are taught to recognize and treat common ailments and what procedures to follow when faced with a seriously ill patient in need of evacuation to the Tanana, Fairbanks, or Anchorage hospital.

All villages in the district are visited periodically by doctors from either Tanana or Fairbanks. Most of the villages have "pretty well-equipped" clinics owned by the village councils, Prior says.

In general the Alaska Native Health Service is "a well co-ordinated system," according to Prior. But the Tanana Service District has one serious problem. The Tanana
hospital is designated the center of the service unit, says Prior. Health aides are usually supposed to make their initial radio contact with that hospital. But Alaska's bush-plane system connects villages primarily with Fairbanks. The result: patients whose condition is known to medical personnel in Tanana are often flown into Fairbanks, where clinic staff know nothing of their problem.

It is a dilemma, Prior admits. Culturally it makes sense for the Alaska Native Health Service hospital to be in Tanana, which "isn't a white man's town" as Fairbanks is. But medically, "it doesn't make sense now" for Tanana to be the center of the system, since it is frequently impossible to evacuate patients from the villages to Tanana.

**The schedule rules.** Doctors as well as patients can find themselves at the mercy of erratic bush-plane schedules. Prior recalls flying south to Fairbanks to catch a plane back north to Barter Island, 300 miles east of Barrow. Upon arriving in Fairbanks, however, she found the scheduled flight had been cancelled; the choice was to return to Barrow, mission accomplished, or charter a single-engine plane to Barter Island. She chartered the flight.

Whether they are seen at one of the service-unit hospitals or in the Fairbanks clinic, native Alaskan patients don't pay for service; medical care is the native's right under original treaty agreements, Prior says. If a patient has insurance or Medicaid, that coverage can be used to pay for laboratory tests, bills at Fairbanks Memorial Hospital or consulting physicians — anything the Alaska Native Health Service doesn't itself provide.

Interviewed during a lunch break in the cafeteria of Fairbanks Memorial Hospital, which adjoins the Alaska Native Health Service clinic, Prior said her morning had centered on a number of matters: two patients had been admitted to the intensive care unit after contracting pneumonia following a bout of flu. Another patient she had seen that morning had been dispatched to the Tanana hospital for longer-term psychiatric care; tentative arrangements had been made to receive yet another patient who might be arriving from Nome with a knife wound. The patient had been sent to Anchorage, but bad weather would probably make it necessary for the plane to land in Fairbanks. She had seen approximately 20 other patients at a well-baby clinic.

Clinic operation is frequently overburdened by patients who arrive from the bush with little understanding or appreciation of the appointment system used.

**Why Alaska?** What brings a doctor to a public health service hospital in Barrow or a clinic in Fairbanks?

While she believes many Alaska Native Health Service doctors "work harder for less return," Prior says she sees medicine as a service. "Personally I can't get involved in medicine as a business." She considers her pay "not inappropriate;" she earns approximately $15 per hour.

Finally, Dr. Prior, her husband and 3-year-old daughter, Rachel, like living in Alaska. "I come from Alaska," she says, "and I'm happy to be back."

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### Facial deformities

(Continued from page 26)

cleft lip when he was two months old and again at 18 months to close the cleft palate. The operations, performed at the Rhode Island hospital where Peter was born, closed the clefts, but nothing could be done at the time to prevent the developmental problems and nasal speech that would develop.

Now 15 and a junior-varsity football player, Peter recalls children made fun of him when he entered a new school. To defend himself against school bullies, Peter began a weight-lifting program. "But I learned that was not the answer," he said.

In addition to congenital anomalies, such as cleft palate, the Institute treats persons with acquired and developmental deformities.

**Results of trauma.** Acquired deformities are those received by "normal" faces as the result of trauma, such as an auto accident or gunshot wound. Doctors at the Institute recently treated a young man who was vaulted over the handbars of his motorcycle and through the windshield of an on-coming car in a head-on collision. He underwent two years of treatment and numerous operations at nearby hospitals before he came to the Institute. After months of treatment at the Institute, he underwent a 17-hour operation with eight attending surgeons to reconstruct his face.

Developmental defects occur when the normal growth pattern is disturbed. Children with developmental defects often appear to have normal cranio-facial structure at birth. The reason their development goes askew is unknown.

An example of a developmental abnormality is a prognathism; a condition in which the upper or lower jaw projects beyond the upper face. In some cases; the more developed jaw is in proper alignment and the problem is caused by stunted growth of the other jaw.

When a patient first comes to the Institute, he receives a thorough physical examination and an evaluation by an oral surgeon, plastic surgeon, orthodontist, pedodontist, otolaryngologist and speech therapist. Photographs, x-rays, molds of the face and study models are developed to aid in diagnosing and studying the problem.

**Course of action set.** When a course of treatment is established, the doctors meet with the parents and the child, if he is old enough, to discuss what the course of action will be, how long it will take to complete and the projected condition of the patient after treatment.

A social worker also talks with the patient and his family to learn how the patient feels about himself and his defect, how the family views the child and how the parents see themselves.

"This is an integral part of the rehabilitation process," Booth said. "It psychologically prepares the parent and child before the commencement of treatment."

During treatment a speech therapist works with the patient trying to help him make his speech as understandable as possible. After treatment and surgery, 75 to 80 percent of cleft palate patients brought to the Institute develop socially acceptable speech, Anastasi said.

The Institute has been in operation for six years and has treated more than 300 patients. It is also involved in research and development of new methods of treatment for cranio-facial abnormalities.
Alumni functions in May drew a number of BUSM graduates back to Boston for updates on their School and to mingle with former classmates at a number of events, such as the outdoor buffet at the School (top photo). In photo at lower left, P. Anthony Penta, M.D., '51 and Mrs. Penta, at left, residents of Melrose, Mass., chat with Mrs. Marvin Krims and Marvin Krims, M.D., '51, of Newton Center, Mass., at a dinner for Dean’s Club members held at the Ritz Carlton Hotel. In photo at bottom right are Herbert Mescon, M.D., outgoing Alumni president (right) and his cousin, Michael H. Mescon, Ph.D., Regents’ Professor of Human Relations and chairman of the Department of Management at Georgia State University, main speaker at the annual Alumni Dinner at the 57 Restaurant in Boston. Story on page 35.
BUSM Annual Fund Campaign reaches $91,190, heads for $100,000

The BUSM Alumni Office reports that $91,190 has been raised for the Annual Fund as of May 1, 1976. Bernard Tolnick, M.D., '43-A, chairman of the Annual Fund Campaign Committee, and Barry M. Manuel, M.D., '58, chairman of the Dean's Club Membership Committee, express confidence that the fund will reach $100,000 before the drive closes on June 30, 1976.

This will be the first time in the history of the BUSM Alumni Association that the Annual Fund, which provides financial assistance for medical students in the forms of scholarships and loans, sponsors student events, and gives support to the School in all areas that it can, will reach more than $100,000.

Since the winter issue of Centerscope, the following have joined the Dean's Club and Century Club, respectively. (A complete list of all alumni who contributed to the 1975-76 BUSM Annual Fund will be listed in the summer issue of Centerscope.)

**DEAN'S CLUB MEMBERS**

John H. Bechtle '50
Arnold I. Blake '50
R. Clement Darling '53
Arnold Goldenberg '54
Malcolm Gordon '48
Michael J. Kannan '33
Marvin B. Krim '51
Bennett Miller '51
David M. Moriarty '47
Felix R. Rosenhain '53
Edward Spindell '53

**CENTURY CLUB MEMBERS**

Edward P. Andersen '64
Neil E. Anderson '48
E.D. Angulo '52
Philip J. Arena '61
Jacob J. Arenstam '32
Betty J. Bamforth '47
John Belsky '34
Franklyn D. Berry '41
David W. Bishop '46
George D. Bissell, Jr. '38
Harold P. Blum '53
David H. Boals '51
Harris E. Bowman '25
Thomas F. Boyd '48

Ernest A. Bragg, Jr. '43-B
Allen G. Braley, Jr. '56
Matthew D. Branch '53
William Farrar Brown '47
Willard E. Buckley '33
Robert S. Burroughs '64
Robert J. Carey '54
Muriel Case-Downer '29
Joseph R. Cataldo '58
John J. Chiarenza '58
Jay D. Coffman '54
Roger M. Cole '47
Gerald M. Collins '41
John F. Connell '33
George M. Connor '35
Mark H. Cooley '60
Robert H. Cowing '51
William F. Croskery '37
Lois B. Crowell '38
A. Edward D'Andrea '60
Elizabeth C. Dooling '65
Saul K. Dopkeen '39
Paul M. Duchesneau '52
John A. Ferriss '45
Edward M. Fine '72
Nathan L. Fineberg '30
George W. Fontaine '60
Edward W. Forbes '69
Frederick L. Fox '55
Walter E. Fox '55
Henry H. Frenkel '52
Job E. Fuchs '44
Ronald S. Gabriel '63
Alumni Association’s annual dinner at the 57 Restaurant brought together old friends and created new ones. At left, Tom Whalen, ‘76 and his fiancée, Elaine Wilson (seated) discuss marriage plans with Bob Sternbach, ‘76, and his fiancée, Debbie Freedman. In photo at right, Alumni Fund chairman Bernard Toinick, ’43-A, and his wife pose for Centerscope camera with Lester F. Williams, Jr., M.D., ’56, and Mrs. Williams. Dr. Williams was named Alumni Association treasurer for the coming year.
Two School of Medicine alumni take top mental-health posts

by Janet Cremone

Two School of Medicine alumni have been appointed to top posts in the Massachusetts Department of Mental Health. Dr. Mary Jane England, BUSM '64, holds the newly created post of DMH associate commissioner, while Dr. William I. Malamud, Jr., BUSM '54, will serve as assistant commissioner for mental health. Dr. Malamud served as assistant superintendent in charge of clinical services for the Solomon Carter Fuller Mental Health Center, recently opened at the Medical Center's South End complex.

The position of associate commissioner in the DMH is a new one created by Commissioner Robert L. Okin, M.D. Before this change, there was a deputy commissioner, and a number of assistant commissioners. The appointment also makes Dr. England the first woman commissioner in the department. She will be responsible for all the programs in the region and will be a direct liaison with DMH staff in the field.

Centerscope decided to interview both doctors, not only because of their appointments and alumni status, but also because of their commitment to the field of community psychiatry. They share a friendship begun when Malamud was England's professor at the School of Medicine. She considers him to have been a "decisive influence" in her decision to specialize in this area.

William Malamud: Taking a chance to make some changes

William I. Malamud, Jr., M.D., has spent almost half his life at the School of Medicine — graduating in 1954, teaching here continuously with the exception of two years' Army duty, and until his recent appointment, serving as assistant superintendent in charge of clinical services for the Solomon Carter Fuller Mental Health Center.

Malamud puts it this way: "BUSM is my second home. I had mixed feelings about leaving for the state DMH position, but I believe that there is a chance of making some changes in the system. I am willing to take time away from what I enjoy to do that."

Malamud is friendly and personal; he dresses conservatively, but stylishly. He dislikes jargon, explaining that this is a quality he shares with his father, whose portrait stands on his desk. (William Malamud, Sr., M.D., was head of the School of Medicine's psychiatry department from 1946 until 1958 and is considered to be the "father" of the department. He is a distinguished psychiatrist and is widely known throughout the profession.)

"Life isn't my own." Making way for the interviewer by taking a pile of papers from a chair in his temporary office, Malamud begins by describing his state post in personal terms: "I find that my life isn't my own around here."

"My new position is a tremendous challenge," says Malamud. "I am responsible for establishing standards for various types of treatment in the state's mental-health institutions and hospitals. The difference between my work here and at the Medical Center is that here I am responsible for system problems, rather than for teaching and supervising." He adds that he tends to think of mental-health problems as "part of a system." He says he follows an analogy that Dr. Bender, former chairman of the psychiatry department, had:

"Doctors traditionally rescue people. The people come down the river and are drowning. The doctor pulls them out, resuscitates them and puts them back on their feet. But there may be someone around the bend who's tossing them in."

Perhaps the greatest challenge Dr. Malamud sees ahead is the build-up of the state's mental-health institutions. At the present, he sees them in "sorry disarray", but believes that the key to improving them is to associate them with other health facilities.

"We have been upgrading the institutions by making contracts with surrounding hospitals. The children at Wrentham State Hospital are treated at Children's Hospital, while the adults there are treated at Peter Bent Brigham Hospital. For each institution, we are trying to get together those kinds of resources to provide the basic medical care that is required."

Interest in aftercare. Aftercare programs, as Malamud sees them, will be another major task for him. He explained that the Department would like to design aftercare programs that are much more global than just having the patient come in and get a shot or a psychiatric interview. He emphasized that such programs "should help to plan the direction that the patient's life will take — how the patient will be productive and how he will enjoy life."

Malamud doesn't begin his biographical information with statistics (Born May 24, 1928, in Boston), but rather more bluntly and colorfully.

"I was born into psychiatry. Not only was my father a psychiatrist, but my mother was a psychiatric social worker. My aunt was supervisor of nurses at Norwich (Conn.) State Hospital, and my uncle was a neuropathologist. I have shrinks all over my family," he says with a twist of a smile. Both Dr. Malamud's brothers are also in the field.

From the age of 11 until he entered Wesleyan University, Malamud lived at Worcester State Hospital, where his father served as clinical director and director of research.

"This environment influenced me a lot. At 14, my parents had me work with a group of patients," he recalls. "I got a feeling for the life of a patient
that I couldn't have received elsewhere."

His interest in community psychiatry was formed while in medical school. "I found that BUSM's Home Medical Service was a very valuable experience in my career," he says. "I really enjoyed going into people's homes and knowing them in a different way."

**Community influence.** Even though Malamud cites his parents as important influences in his career, he believes that Gertrude Cuthbert, the first director of the Roxbury Multi-Service Center, influenced him into entering the field of community psychiatry. "I got involved with her concept of a multi-service center. I thought it was an excellent idea," he says. In 1968, Dr. Malamud received a National Institute of Mental Health grant to explore the role between a mental-health center (Fuller) and a community controlled multi-service center (Roxbury Multi-Service Center). He has also served as consultant to the South End Neighborhood Action Program and the South End Community Health Center. These projects, he estimates, involved several thousand home visits.

Teaching and working with patients are two things that Malamud enjoys most. He continues a very limited private practice and still teaches two courses at BUSM.

Prior to his appointment at Solomon Carter Fuller Mental Health Center, Malamud served for a year as a professor in BU's Overseas Program, teaching and organizing human-service activities for military communities in Germany and Italy.

**A time to relax helps.** Malamud's work week averages about 50 hours. An avid tennis player, he says he enjoys "full" days, but likes to have a chance to relax. However, he finds that difficult, having five daughters and a son to occupy his private life. His oldest daughter is currently attending BU. Malamud and his wife, Camila, a Spanish teacher at Regis College in Weston, Mass., have found time to travel extensively throughout the United States and Europe. The Malamuds live in Newton, Mass.

Reflecting on his new position, Malamud says, "I am eager to make some changes, but I eventually would like to go back to BUMC. I realize that I am missing what I have left behind."

**Mary Jane England: Committed to the city and its children**

Mary Jane England, M.D., '64, works 60-hour weeks, takes work home at night and on weekends, involves herself in community projects and raises three children. But this sort of activity is what the long-time advocate of children services says she prefers. It is her way of "understanding the system that controls these services."

While being interviewed in her comfortable, plant-filled office, England was interrupted six times. She apologized, explaining that this is her typical day — back-to-back appointments and constant interruptions.

**In cool control.** However, she is in cool control, bearing myriad responsibilities with calm precision and ease. England doesn't remember ever having a "9 to 5" job. Her positions, which are of impressive administrative background, have always required what seem to be superhuman schedules.

As director of child psychiatry at St. Elizabeth’s Hospital in Boston's Brighton section from 1969 to 1972, England established children's mental-health services and consulted with child and youth programs and pediatric in-patient services. In the meantime, she worked evenings on University Hospital's Recalls Robby-3 service. In my senior year in medical school," she recalls, "I spent a month on University Hospital's Robby-3 psychiatric service. I realized then that many of the problems that adolescent girls had were psychiatric rather than strictly medical. There were a lot of key people who had a decisive influence on my career — Drs. Richard Plllard, Dick Kahn and, of course, Bill Malamud, who influenced me in the field of community psychiatry. The skills gained through such faculty at BUSM and, in particular, Dr. Eveleen Rexford, chairman of the Department of Child Psychiatry, are key factors in allowing me to assume my new role in managing the Department of Mental Health."

England becomes impassioned in a discussion of child psychiatry and children's services. "My major problem now is recruiting trained child psychiatrists; there just aren't enough. They are usually trained in adult services. I am kind of a community child psychiatrist, being interested in the social networks of services for children: the neighborhood health centers, the schools and the courts — services located close to the child's home. I'll always have a particular interest in children's services, to make sure that they are getting a fair share. (Continued on page 36)
Alumni News

CLASS NOTES

1925
HARRIS E. BOWMAR retired three years ago and moved to North Scituate, Mass., after 45 years in Weymouth, Mass.

1930
HARRIS E. BOWMAR retired three years after 45 years in Weymouth, Mass.

1932
EVA S. VANDOW has an active practice in psychiatry in Riverdale, N.Y. She is also on the faculty of the Albert Einstein College of Medicine.

1933
GUY B. ATONNA has been named to the state Board of Medical Examiners of Arizona by Gov. Raul Castro. Dr. Atonna currently resides in Douglas, Ariz.

1934
PHILIP E. ZANFAGNA of Methuen, Mass., was elected president of the Northeast Region of the American Association for Clinical Immunology and Allergy at the association's annual meeting in Palm Springs, Calif. He is also a diplomat of the American Board of Clinical Immunology and Allergy and a member of the American Academy of Allergy, the American College of Allergy, the New England Society of Allergy, and the American Society for the Study of Headache. Dr. Zanfagno is listed in Who's Who in the East, International Biography and Outstanding Americans of Italian Descent in Massachusetts.

1938
THEODORE A. POTTER writes, "Have happily moved my office to 1180 Beacon St., Brookline [Mass.], and surgery to New England Baptist Hospital [Boston], where I continue to perform reconstructive procedures for arthritis." He is now a clinical professor of orthopedic surgery of Tufts University School of Medicine, teaching residents and fellows.

1944

1954
GEORGE DERMKSIAN has been practicing cardiology and internal medicine in New York City for 16 years. He has been appointed attending physician and cardiologist at St. Luke's Hospital Center in N.Y.C. and assistant clinical professor of medicine at Columbia University, College of Physicians and Surgeons.

1957
JOHN C. CONIARIS is in his 10th year as director of the Youth Guidance Center in Framingham, Mass. He is president-elect of the New England Council of Child Psychiatry.

1961
STAFFORD I. COHEN is director of the medical intensive care unit at Beth Israel Hospital in Boston. He is a fellow of the American College of Physicians, the American College of Cardiology, and the Clinical Council of the American Heart Association.

1962
M. JOYCE RUBISSOW is in Exeter, Devon, England, where she is helping develop effective medical care for severely handicapped infants within the National Health Service. She also works in "paediatric" neurology in Exeter.

1963
CHESTER JOHN FLYNN has joined Dr. Charles Southern to practice internal medicine in Bremham, Texas. In 1967 Dr. Michael E. DeBakey personally invited Dr. Flynn to join his team. Dr. Flynn subsequently became director of the Cardiac Monitoring Department at the Methodist Hospital and director of the Cardiac Monitoring Laboratory at Baylor College of Medicine, where he is an associate professor.

1964
MARY JANE ENGLAND, a child psychiatrist in Brighton, Mass., has been named associate commissioner of the Massachusetts Department of Mental Health. (A feature article on Dr. England appears elsewhere in this issue.)

1966
ERIC A. BIRKEN, now at the Wright-Patterson Air Force Base in Ohio, will leave the Air Force in July and begin practice in Rochester, N.Y. He and his wife announce the birth of their first son, Adam Scott, born Jan. 19, 1976.

1976
BARRY E. SIEGER finished his fellowship in infectious disease at the University of Florida Medical Center in June, 1973. He then joined the staff of the Brooke Army Medical Center, Department of Medicine, Infectious Disease Section, San Antonio, Texas, where he spent two years in an Army teaching hospital. He became involved in research in the medical center's burn unit, and published the results of some of his work. He later assumed the

Freed elected Alumni president

More than 200 alumni, students and guests attended the 101st annual meeting and banquet of the Alumni Association of BUSM at the 57 Restaurant Saturday, May 1. Elected officers of the Association for the coming year were: Murray M. Freed, '52, president; Alan S. Cohen, '52, first vice president; P. Anthony Penta, '51, second vice president; Job Fuchs, '44, secretary; Edward Spindell, '53, assistant secretary; Lester F. Williams, Jr., '56, treasurer; Donald T. Devine, '50, assistant treasurer; and Barry M. Manuel, '58, auditor.

Appointed to the Association's Board of Directors were: (term expiring in 1977) Elizabeth C. Dooring, '65, and Anna Silverman Barouchoff, '49; (term expiring in 1978) Donna R. Barard, '65, and Martin B. Levene, '50; (term expiring in 1979) Arnold L. Benner, '46, and Judith L. Vaitukaitis, '66. Named to the Nominating Committee were Peter E. Pochi, '55, chairman; Elizabeth Dooring and Martin Levene.

Michael H. Mescon, Ph.D., Regents' Professor of Human Relations and chairman of the Department of Management at Georgia State University, spoke on the roles and responsibilities of individuals and institutions. Cohen presented outgoing president Herbert Busco, M.D., with a replica of a rocking chair representing the real chair Mescon will receive from the Association in appreciation of his service over the past year. Dean Sandson addressed the gathering, extending thanks to Bernard Toilick, '43, Alumni Fund chairman, and Barry Manuel, membership chairman for the Dean's Club, for their outstanding work in raising funds for the School.

Alumni Day activities had begun earlier on the day of the banquet with registration and coffee in the lobby of the Instructional Building, followed by a talk by Dean Sandson. The annual luncheon was served under a striped awning on the Green, and was followed by an enthusiastically received seminar on "The Physician and Estate Planning," presented by David K. Farnsworth, Boston University Director of Planned Giving, and featuring a panel of three Boston attorneys specializing in estate planning.
position of director of medical education for internal medicine and chief of the Infectious Disease Service at the Orange Memorial Hospital in Orlando, Fla. The hospital is affiliated with the University of Florida Medical Center, where Dr. Sieger also serves as a clinical assistant professor of medicine.

1969
LESTER K. HENDERSON’s wife writes from Skowhegan, “We all love Maine. Peter is doing great things in these parts. Our best to all!”

1970
ROBERT S. GALEN has co-authored with S. Raymond Gambino a book entitled Beyond Normality: The Predictive Value and Efficiency of Medical Diagnosis. Dr. Galen is director of Clinical Chemistry of Metopath, Inc., Hackensack, N.J., attending pathologist at Presbyterian Hospital, and assistant professor of clinical pathology at the College of Physicians and Surgeons, Columbia University.

1971
STEPHEN G. GREEN writes, “I am in the Navy working in the Department of Family Practice in Camp Pendleton, Calif. My wife, Karen, and I are proud to announce the birth of our first child, David Aaron, born Feb. 25, 1976.”

1972
EDWARD M. FINE has completed a three-year family-practice residency at Lancaster General Hospital in Lancaster, Pa. He is now working in a three-man family practice group in Meadville, Pa., where he lives with his wife, Gail, daughter, Heather, 2 1/2, and son, Jonathan, 6 months.

1973
BARBARA J. WILKINSON is currently a pediatric resident at the Maine Medical Center in Portland. In July she will begin a neonatology fellowship in Rochester, N.Y.

Late notes
1914
EDWIN D. LEE writes from Exeter, N.H., “Still going strong. I enjoy Florida in the winter for two months.”

1927
LADISLAUS B. SLYSZ is still in general practice in New Britain, Conn., after 49 years.

1930
NATHAN L. FINEBERG of Newton Centre, Mass., was selected as one of the four “Physicians as Artists,” for a show of sculpture, paintings, and photography. The exhibit was sponsored by the Boston Safe Deposit and Trust Co. and was held at their Boston headquarters during December, 1975, and the first week of January, 1976.

1942
HAROLD KARLIN of Boston writes that his son, Bruce, is a 1976 graduate of the University of Massachusetts Medical School. His internship will be at St. Vincent’s Hospital in Worcester, Mass.

1951
JORGE W. MAYORAL-BIGAS writes from Ponce, Puerto Rico, “I sincerely regret to have missed the 25th Alumni Meeting (1951). My warmest greetings to my former classmates and wish them the best of everything.”

1953
MATTHEW D. BRANCHE writes from New Rochelle, N.Y., “Your notice of the Annual Alumni Meeting and Banquet came at a time when I was selected as a member of the medical delegation for the U.S. Olympic team in Montreal this summer. Unfortunately, there is a planning conference for the games in Plattsburgh during the same dates and I will not be able to be present at the School’s meeting. I do look forward to attending next year’s gathering. Am happy to represent BUSM at Montreal!”

1955
NLOGHA E. OKEKE, who has been practicing in New Bedford, Mass., has been requested to return to Nigeria to take charge of the administration of the Eastern Nigeria Medical Center. He writes, “This is a good opportunity for me to serve my people again.”

1956
AMES ROBEY of Ann Arbor, Mich., left Michigan state service as of Jan. 1, 1976. He is now in full-time private practice of psychiatry and forensic psychiatry, doing business as Michigan Forensic Services. At the present time, his staff, full- and part-time, totals only six, but he expects it to increase. Two of his children are now at the University of Michigan; the oldest is heading for medicine and may well return to the New England area and apply to BUSM.

1959
ARNOLD WONG writes from Fremont, Calif., “Recovered from MI in June, 1974. Resumed all activities — skiing, hunting, bowling, cycling, and golfing. The ‘doc’ said ‘kung fu’ is bad for the heart, so must give up one activity. It’s great to be ALIVE!”

1971
ELIZABETH WOOD has set up private practice in Brockton, Mass., and is on the staff at Beth Israel and St. Elizabeth’s Hospitals. She also teaches physical diagnosis at Tufts University School of Medicine.

1974
PAUL M. LEIMAN announces from East Meadow, N.Y., that his wife Carol gave birth to their first child, Scott Elliot Leiman, on April 25, 1976. Dr. Leiman has just been elected president of the Housestaff Association at the Nassau County Medical Center, New York.

England (Continued from page 34)
of the department’s resources...”

’77 budget $230 million. She is currently working on the Department’s 1977 budget, which is approximately $230 million. England will be responsible for this budget along with the 18,000 employees within the DMH. The Department of Mental Health is the largest landholder in Massachusetts, controlling 10 state hospitals, seven state schools for the retarded and numerous mental-health centers and clinics for which Dr. England is accountable.

Time is a precious commodity for England, but she believes that she has learned to structure and organize her professional career as well as her social life.

‘Exceptional organizer.’ “Mary Jane’s strengths are also in administration. She’s an exceptional organizer,” says Dr. Malamud. Barbara Horgan, England’s secretary, agrees, adding that even the stacks of papers on her desk are neatly organized.

There’s more to Mary Jane England than just her professional career. The opera-, symphony-, and theater-lover has recently developed an interest in archeology. “I can’t travel much in this job, but I recently visited the Yucatan Peninsula in Mexico. I enjoy reading about archeological sites and studying about the people of the area. I guess you could call me a lover of people.”

She spends her free time with her husband, Robert, their two daughters, Alexandra, 12, Kara, 10, and their son, Thomas, 6. “Weekends are special times for me. I try not to take home much work. Bob and I organize our free time so that it is spent with the children. I enjoy skiing and skating because I can do it with the family.”

“When I told my children about my promotion to associate commissioner, they turned to me in amazement and said: ‘But Mom, we’ve always thought you were commissioner!’”
(Continued from Page 4)

Mass.; Carney Hospital, Dorchester, Mass.; internal medicine.

David W. Civalier, Deptford, N.J.; Highland General Hospital, Oakland, Calif.; flexible.

*Deborah J. Cotton, Boston, Mass.; Beth Israel Hospital, Boston, Mass.; internal medicine.

Russell C. Dabrowski, Short Hills, N.J.; Medical College of Wisconsin Affiliated Hospitals, Milwaukee, Wis.; internal medicine.

Stuart L. Davidson, Somerset, Mass.; Georgetown University Hospital, Washington, D.C.; surgery.

*Carl E. Dettman, Wooster, Ohio; Veterans Administration Hospital, Boston, Mass.; internal medicine.

Joseph G. Duffy, Watertown, Mass.; Swedish Hospital Medical Center, Seattle, Wash.; diagnostic radiology.

Conrad P. Ehrlich, Patchogue, N.Y.

James E. Ehrlich, Rockville Centre, N.Y.; University of Colorado Affiliated Hospitals, Denver, Colo.; anesthesiology.

Michael H. Finch, Camarillo, Calif.; Kaiser Foundation, Los Angeles, Calif.; pediatrics.


Loring S. Flint, Jr., Everett, Mass.; Michael Reese Hospital, Chicago, Ill.; internal medicine.

Gail P. Gaddis, Chicago, Ill.; Los Angeles County-USC Medical Center, Los Angeles, Calif.; flexible.

Linda M. Gaudiani, Indianapolis, Ind.; Boston City Hospital, Boston, Mass.; internal medicine.

Lawrence D. German, Glenview, Ill.; Strong Memorial Hospital, Rochester, N.Y.; internal medicine.


Mark S. Goulston, Newton, Mass.; Los Angeles County-Harbor General Hospital, Torrance, Calif.; psychiatry.

**Glenn J. Green, Newburgh, N.Y.; Veterans Administration Hospital, Boston, Mass.; internal medicine.

Richard M. Greenberg, Ft. Lauderdale, Fla.; Wayne State University Affiliated Program, Detroit, Mich.; internal medicine.

*Peter T. Greenspan, Cambridge, Mass.; Massachusetts General Hospital, Boston, Mass.; pediatrics.

Neil J. Grossman, East Meadow, N.Y.; University of Maryland Hospital, Baltimore, Md.; pediatrics.

Howard D. Groveman, Middle Village, N.Y.; University of Miami Affiliated Hospitals, Miami, Fla.; family practice.

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*Rachelle Halpern, Brookline, Mass.; University Hospital, Boston, Mass.; internal medicine.

William D. Hauger, Westminster, Mass.; Walter Reed Army Medical Center, Washington, D.C.; internal medicine.

T. Arthur Hawley, Framingham, Mass.; Framingham Union Hospital, Framingham, Mass.; flexible.

Stephen L. Hill, Jamaica, N.Y.; Wm. A. Shands Hospital, Gainesville, Fla.; surgery.

David Hochberger, Tuckahoe, N.Y.; Mt. Sinai Hospital, New York, N.Y.; obstetrics-gynecology.

Robert M. Jackson, Somerset, Mass.; University of Miami Affiliated Hospitals, Miami, Fla.; internal medicine.

Mirka A. Jaros, Jamaica Plain, Mass.; University of Miami Affiliated Hospitals, Miami, Fla.; family practice.


Matthew R. Kaufman, Marblehead, Mass.; Cleveland Metropolitan General Hospital, Cleveland, Ohio; internal medicine.


David G. Kern, Pawtucket, R.I.; Veterans Administration Hospital, Boston, Mass.; internal medicine.

Ethan H. Kisch-Pniewski, Cambridge, Mass.; New York University Medical Center-Bellevue Hospital, New York, N.Y.; psychiatry.

<table>
<thead>
<tr>
<th>Name</th>
<th>City</th>
<th>Hospital/Program</th>
<th>Specialty</th>
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<tbody>
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<td>Kenneth H. Kline</td>
<td>Escondido, Calif.</td>
<td>University of Miami Affiliated Hospitals, Miami, Fla.</td>
<td>Family practice</td>
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<tr>
<td>Lawrence S. Kluger</td>
<td>Riverdale, N.Y.</td>
<td>Montefiore Hospital Center, New York, N.Y.</td>
<td>Internal medicine</td>
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<tr>
<td>Elaine M. Kondroski</td>
<td>Lynn, Mass.</td>
<td>Boston University Affiliated Hospitals, Boston, Mass.</td>
<td>Surgery</td>
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<td>Phyllis J. Korneguth</td>
<td>Waban, Mass.</td>
<td>New England Medical Center Hospital, Boston, Mass.</td>
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<td>Louis L. Kralick</td>
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<td>Blodgett Memorial Hospital, Grand Rapids, Mich.</td>
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<td>Karen W. Landau</td>
<td>Fort Lee, N.J.</td>
<td>Mt. Sinai Hospital, New York, N.Y.</td>
<td>Internal medicine</td>
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<tr>
<td>Beverly L. Landry</td>
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<td>Howard University Affiliated Hospital, Washington, D.C.</td>
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<td>David Lee</td>
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<td>*David J. Leehey</td>
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<td>Hospital of St. Raphael, New Haven, Conn.</td>
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<td>University Hospitals, Madison, Wis.</td>
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John F. Schneider

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Bennett Blumenkopf
Bertha Curtis Award
Maureen A. Strafford
Elizabeth K. Moyer Memorial Award
Bennett Blumenkopf
Pediatrics Award
Hubert A. Russell

IN PRINT
ROBERT S. GALEN, M.D., M.P.H., Class of '70, (and S. Raymond Gambino, M.D.) Beyond Normality: The Predictive Value and Efficiency of Medical Diagnosis. John Wiley & Sons, 1975. 250 pp. $14.95. Rejecting the standard definitions of "normal" and "abnormal" in the interpretation of clinical test results, the authors emphasize the important roles of prevalence, sensitivity, specificity, and predictive value in laboratory analysis. Galen is director of clinical chemistry of Metpath, Inc., attending pathologist at Presbyterian Hospital, and assistant professor of clinical pathology at the College of Physicians and Surgeons, Columbia University.


MORRIS P. RUBEN, D.D.S., professor of stomatology and assistant dean for post-doctoral program; HENRY M. GOLDMAN, D.M.D., dean of the School of Graduate Dentistry; FRANK G. OPPENHEIM, D.M.D., Ph.D., assistant research professor in oral biology; and seven other dental clinicians, Periodontal Disease, A Didactic and Pictorial Review. Boston University School of Graduate Dentistry Press, 1975. 267 pp. $10 (paper).


EUGENE LAFORET, M.D., assistant clinical professor of surgery, the following articles: "The fiction of Informed Consent," JAMA, April 12; "Acute Hemorrhagic Incarceration of Prolapsed Gastric Mucosa," Gastroenterology, April; with co-authors ROBERT D. BERGER, M.D., professor of surgery, and CHARLES W. VAUGHAN, M.D., associate clinical professor of otorhinolaryngology, "Carcinoma Obstructing the Trachea: Treatment by Laser Resection," New England Journal of Medicine, April 22.

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