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Newswatch

A quick flip through a few of the many newscaps that have recently featured the words and works of Boston University Medical Center professionals:

Woman's Day magazine, in a major article entitled "New Babies Are Smarter Than You Think," in its June issue notes with interest the child-development research of Louis Sander, M.D., whose studies at BUMC were the subject of a Centerscope article in the Fall, 1975 issue. . . . H. Emerson Thomas, M.D., co-director of the BUMC MR FIT (Multiple Risk Factor Intervention Trial) program is quoted at length in a Lowell (Mass.) Sun article on hypertension, Thomas suggesting that the very word "hypertension" lends itself to the misconception that "hyper" or "tense" persons are more prone to the condition, when in fact there are generally no such obvious symptoms of the condition . . . The OB/GYN News, published in New York, reports on a BUMC study of women receiving prenatal care, noting that a team of researchers from the School of Medicine suggest that the ideal time to persuade alcoholic women to reduce their drinking is during pregnancy, and that some heavy drinkers who do cut down on their alcohol intake produce normal babies . . . Henry L. Rosett and Eileen M. Ouellette report that few differences were noted in their study between the offspring of the abstinent and moderately drinking women, but that only 20 percent of infants born to women who continued to drink heavily were normal . . . The Knickerbocker News in Albany, N.Y. features on page one a survey of four well-known psychiatrists and psychoanalysts on the topic, "How Many Years of Psychoanalysis Are Enough?" and quotes Jacob Swartz, M.D., professor of psychiatry and associate dean at the School of Medicine: "Severity of disturbances determine length of treatment. The average is three to five years. Some patients have gone for as long as eight to ten years. This is justified only if the doctor is absolutely certain there is movement. Are there changes in the patient's life, work, relationships with other people? . . . If there are doubts, a three-to-six-month trial could be considered . . . " The Linien, N.D. Emmons County Record reports that a "Tribute to Motherhood" is to be the theme of a Bicentennial Breakfast at the Holiday Inn in Bismarck, N.D. under the sponsorship of the North Dakota Right to Life Association. Principal speaker at the event will be Mildred Jefferson, M.D., president of the National Right to Life Committee and assistant clinical professor of surgery at the School of Medicine . . . The Jewish Digest of Houston, Texas, reprints from Chemical and Engineering News an article on Martin L. Albert, M.D. of BUMC's Aphasia Research Center. Dr. Albert catches the attention of these diverse publications with his study of the possibility that Israeli citizens respond incorrectly to questions involving left-right orientation more often than do non-Israelis. (He found that they do, and perhaps it is because of the way they read.) . . . Playboy magazine weighs in with an article in its June issue (under the title, "Sex is Good For Your Health") that describes the research of Robert M. Rose, M.D., of the School of Medicine, and two associates at the Yerkes Regional Primate Center in Lawrenceville, Ga. The article says that studies on "Quid," a male rhesus monkey, by Rose and his fellow scientists demonstrated how testosterone levels can be raised and lowered without medication. Changes in sexual and other activities. (The article does point out that Rose and his associates say their experimental results can be interpreted in more than one way. It is conceivable that Quid and his fellow male subjects had a rise or fall in testosterone due to their dominance in the group of animals, rather than as a result of their sexual arousal and sexual experiences.) . . . In the Lebanon (Pa.) News, one reads that D. Frank Benson, M.D. a professor of neurology at the School of Medicine, feels that children with learning disabilities usually outgrow them and should not be forced to learn to read. Benson, speaking at a symposium on remedying mental retardation, says that children with dyslexia have normal IQs and are extremely bright. The children with this condition are simply not able to read in their early years, the newspaper quotes Benson as saying. . . . Jeanne F. Arnold, M.D., a School of Medicine faculty member and BUMC graduate married to Peter Jeffries, M.D., another BUMC graduate, now writes a column, "Your Family Physician," in the Manchester, N.H. Union Leader. . . . Readers of the Hawaii Times learn a new word, "cancerophobia," coined by Franz J. Ingelfinger, M.D., editor of the New England Journal of Medicine and clinical professor of medicine at the School of Medicine, Ingelfinger, says the Times believes the fear of cancer is becoming a serious social problem among Americans. "There are two ways of dying," the Times quotes Ingelfinger as saying: "the ordinary and reasonably good way, and the bad cancer way." . . . In an article entitled, "Health Through Instrumentation," Industry magazine tells of the unique collaboration between the University Hospital Trauma Center and Instrumentation Laboratory, Inc. in the development of a cardiac output system that measures the quantity of blood pumped within a minute, allowing physicians to guide fluid and drug therapy carefully in treating trauma victims. Newspapers across the country sensationalized the story of the boy John, who was thought to have been raised by monkeys in Burundi, and made much of the trip in April by BUMC psychiatrist Richard Pillard, M.D., and Northeastern University psychologist Harlan Lane, Ph.D., to examine and perhaps rehabilitate him. Less sensational was the story uncovered by Pillard and Lane: that the boy was severely mentally retarded, perhaps as the result of encephalitis at about age two. "His history had been lost by inadequately kept records in a country with a strong oral tradition" said Pillard.
An electronic unit has enabled quadriplegic patients at UH to switch on lights, dial the telephone and perform other once-impossible tasks. Page 18.
The crucial role of state support in medical education
by John I. Sandson, M.D.
Dean, BUSM

As medical schools continue to grapple with the problems of increasing tuitions and shrinking capitation grants, the important role of state support of medical education is not generally appreciated. More than 90 percent of medical schools receive monies from their states.

In 1974, 67 of the nation's 110 medical schools were state schools. Of the 43 private medical schools, 33 were eligible for subsidies from their states. (In New York and Pennsylvania these subsidies amount to more than $3,000 per year per student.) Of the remaining 10 private schools, the three in the District of Columbia (Howard, Georgetown and George Washington) receive very substantial special subsidies from the federal government. No support for 7. That leaves only seven out of 110 medical schools in the country receiving no state support or special federal subsidy, among them the three private medical schools in Massachusetts, including Boston University School of Medicine.

The net cost of medical education is now estimated to average between $12,000 and $15,000 per year per student, based on studies by the Institute of Medicine and the Association of American Medical Colleges. These costs are met to varying degrees in the schools by tuition, federal capitation grants, endowment income (private philanthropy) and state support. The Association of American Medical Colleges has recommended that the cost of medical education be borne by all who benefit from it and has suggested that the student, the federal government, and the state government each cover about one-third of the cost.

Tuition is increasing in most medical schools — and rather markedly in the private medical schools. The average increase in tuition among private medical schools for next year is 19.1 percent. Meanwhile, federal capitation grants have decreased by 40 percent in the past two years, and expansion of this type of support is very unlikely. Many schools have tried to meet some of the costs by increasing private philanthropy. This may provide transient relief for a few institutions, but it will not alleviate the rising costs for most of our medical schools.

Role of the state. That leaves, as a source of support, the states, whose involvement in medical education has been quite significant. Most state medical schools give preference for admission to students from their states and charge a very low tuition for state residents. Currently most state-supported medical schools do not have a mandatory requirement that students do service in their state after graduation or pay back the "true" cost of their education. Most states operate on the premise (completely unproven) that a high percentage of state residents who go to medical school in the state will ultimately practice in the state.

State support of medical education has been a very positive force. It has made it possible for a majority of the medical schools to function with some sense of stability. The main problem with the present system of state support of medical education is that it creates some significant inequities:

1. The most obvious inequity relates to the seven schools that receive no state subsidy. Some of the seven may not want or need the subsidy, but those that do should be able to receive it. In Massachusetts it is now legal for the state to subsidize private colleges and universities in the state. In fact, Massachusetts has for a number of years been subsidizing the medical education of 100 Massachusetts residents at the University of Vermont College of Medicine. It is now time for Massachusetts to help its private schools of medicine train Massachusetts residents.

2. Students from states with small populations, but with a state medical school, probably have a greatly enhanced possibility of being admitted to medical school. This could perhaps be justified if the individual assumed some obligation to render service to the state; but without such obligation, the intrinsic fairness of this system needs to be evaluated in view of the extremely competitive nature of medical-school admissions.

3. Students with equal financial resources may finish medical school with widely disparate loan obligations. Student A, with no financial resources, can easily wind up with a $40,000 debt after four years of medical education in a private medical school. Student B, with no financial resources, but attending a state medical school, may end up with a debt only half as large. Both students could well have equal ability and equal financial need, and be from the same state. Both may well have wanted to be admitted to the state school. Should the student at the state school wind up with about $20,000 less debt and no service obligation to the state?

Outlook is unclear. The long-term projections for financing medical education are unclear. I imagine the approach at the federal level will be to let the students assume more and more of the financial responsibilities for the cost of their education, but to provide students with more National Health Service Corps scholarships and more federally guaranteed (but not subsidized) loans. It is to be hoped that a system will evolve that will allow most students to choose freely either to do service or to assume the costs of their medical education.

Most states will continue to maintain their own medical schools. Tuitions in the state schools may go up significantly, or some of the states may require students to make commitments to do service in the state. How such a commitment would be
coordinated with the National Health Service Corps would have to be worked out. It is to be hoped that those few states that do not now subsidize their private medical schools will begin to do so. I will work hard to achieve this in Massachusetts.

Without such state support, the private schools without significant endowment will have to raise tuition higher and higher. As long as medicine remains the attractive profession it currently is, these schools will continue to attract good students, but the socio-economic mix of the student body will probably change. The private medical schools may well soon be attended primarily by children of fairly wealthy families. Such a development would represent a change from the direction in which most medical schools—and American medicine as a whole—have been trying to move.

Stumbling-blocks to system-wide hospital planning
by John H. Betjemann
Administrator, University Hospital

(The following is the first of a series of articles by Mr. Betjemann on health-care planning, with special emphasis on hospital and health-care planning in Massachusetts.)

There was a time not so long ago when system-wide health care planning and hospital planning, if they were thought of at all, were considered visions from a far-off future. Hospitals enjoyed the image of the stately institution on the hill, combining medical care of the citizenry with community service and civic pride. Nearly every community wanted a hospital, and most large communities got one.

That time is past. There is a growing public sentiment that there are now too many, too small hospitals and too many hospital beds; and too few primary care physicians and too many specialists. In the opinion of many public officials, hospitals have failed to cooperate with one another in planning to limit resources and avoid duplication of effort.

Partly as a response to these conditions, consumers, planners and regulators have entered the picture and are having a significant effect both on the public's perceptions of hospitals and on hospitals themselves. Public Law 83-641 (the National Health Planning and Resources Development Act of 1974) was conceived, debated and passed with very little fanfare, although it could turn out to be the most important piece of federal health-care legislation passed in our lifetime. Its success or failure will depend on a variety of factors and issues currently unfolding, as health services agencies (HSA's—the new instruments of federally mandated health-care planning) begin to carry out their task.

System-wide health-care planning, no longer a vision of the future, has become very real. It involves real people with genuine, although sometimes conflicting, goals for monitoring and planning a new health-care delivery system in this country and in this state. Progress will be slow and agonizing, but it will be persistent. It is to be hoped that the outcome will be something better than what now exists.

In this first article I would like to address the perceived past failure of many hospitals to plan beyond their immediate community and to relate optimally to other provider agencies or institutions. To understand this phenomenon, it is important to understand something about the internal dynamics of hospitals and certain marketplace phenomena that influence hospitals in their relationships—or lack of them—with each other.

The following review of certain characteristics of the present system that have militated against planning among and between hospitals is this writer's attempt to develop a better understanding of the circumstances that may have to be overcome if hospitals are to cope with the changing social environment and respond to the public's demand for more interhospital and system-wide planning.

**Competition is intense.** Despite the non-profit nature of the industry, competition in every segment of health care is intense. Hospitals compete with each other for patients, for physicians, for the best services and facilities and for public esteem. Where there are excess beds and specialty facilities, competition among hospitals is engendered by the effort to use these resources maximally in order to "spread fixed costs" and achieve the best fiscal results. This is a basic economic drive that exists in any business even when the supply of facilities is limited. Such competition may or may not allocate resources as rationally as a competitive marketplace normally might be expected to do.

Largely because of this fierce competition (and also partly because of third-party reimbursement methods), incentives for hospitals to limit resources and utilization, and to cooperate, have been few, except where they are forced to do so by outside regulators. Indeed, there have been strong economic incentives not to cooperate. Now, however, while the competitive spirit remains strong, a more active regulatory environment is beginning to change all that. While economic incentives for hospitals to work together have not increased perceptibly, political pressures have. Increasingly, due more to negative pressures than to positive incentives, the relative advantages of system-wide joint planning are beginning to be appreciated.

Factors contributing to the rugged individualism and centripetal behavior of many hospitals include fiscal considerations, the educational climate, and the goals and priorities of physicians, hospital administrators and boards of trustees.

An upward spiral. In the medical-care marketplace, supply creates demand instead of the reverse. Cost reimbursement, unit-cost reimbursement ceilings and other third-party payment mechanisms encourage increased utilization and, hence, increased supply, which in turn creates pressure to utilize the increased supply to the fullest. Thus, an upward spiral is formed, and is further encouraged by a fiscal marketplace that penalizes less than maximum utilization of fixed assets.

One result in many areas has been an excess of resources, such as beds and certain specialty facilities. Since any reduction in utilization and/or costs results in reduced revenues, the incentive to reduce utilization and costs is lacking. In addition, unit-cost reimbursement ceilings intensify the economic pressure on hospitals to maximize patient volume.

What price education? The abun-

(Continued on page 27)
Legal Signs

Informed consent: Artificial heart case holds important lesson
by George J. Annas, J.D., M.P.H.

Because of the extensive publicity in both the lay and medical press, most readers will recall that in April, 1969, Dr. Denton Cooley implanted an artificial heart developed by Dr. Domingo Liotta into the chest of Haskel Karp. Karp survived for approximately 64 hours on the device, but died about a day after it was replaced by a human donor heart. The operation, the first of its kind, occasioned great debate. Dr. Liotta was tired by Dr. Cooley's success, but died about a day after it was performed. A verdict was rendered in favor of the doctors by the trial court, and affirmed on appeal in October, 1972, by the Fifth Circuit of the U.S. Court of Appeals. The case merits attention not only because of the doctors involved, but because of the lessons it teaches about the importance of informed consent. A verdict was directed in favor of the doctors by the trial court in October, 1972, and affirmed on appeal in April, 1974, by the Fifth Circuit of the U.S. Court of Appeals. The case merits attention not only because of the doctors involved, but because of the lessons it teaches about the importance of informed consent. A verdict was directed in favor of the doctors by the trial court in October, 1972, and affirmed on appeal in April, 1974, by the Fifth Circuit of the U.S. Court of Appeals.

Mrs. Karp's major contention was that Dr. Cooley had failed to obtain adequate informed consent for this exceptional and experimental procedure. At the trial it was established that Dr. Cooley had discussed the procedure with Mr. Karp at least two occasions, and that Mr. Karp had signed two consent forms on two other occasions. The first form was the hospital's general consent form, which he signed upon admission. It read:

"I hereby authorize the physician or physicians in charge of Haskel Karp to administer any treatment; to administer such anesthetics; and perform such operations as may be deemed necessary for the diagnosis and treatment of this patient."

This is often termed a "blanket" consent form, and is usually held by the courts to be insufficient consent for surgical procedures because of its lack of specificity. If Dr. Cooley had relied exclusively upon this consent form he would have probably lost this case instead of winning it. About three weeks after hospitalization, however, and prior to the operation, Mr. Karp signed, and Mrs. Karp witnessed, the following consent form:

"I, Haskel Karp, request and authorize Dr. Cooley and authorize Dr. Denton Cooley and such other surgeons as he may designate to perform operation upon me, in St. Luke's Episcopal Hospital of Houston, Texas, cardiac surgery for advanced cardiac decompensation and myocardial insufficiency as a result of numerous coronary occlusions. The risk of this surgery has been explained to me. In the even event cardiac function cannot be restored by excursion of destroyed heart muscle and planned location of the ventricle, and death seems to be imminent, I authorize Dr. Cooley and his staff to remove my diseased heart and insert a mechanical cardiac substitute. I understand that this mechanical device will not be permanent and ultimately will require replacement by a heart transplant. I realize that this device has been tested in the laboratory but has not been used to sustain a human being and that no assurance of success can be made. I expect the surgeons to exercise every effort to preserve my life through any of these means. No assurance has been made by anyone as to the results that may be obtained."

I hereby consent to the photographing of the operation to be performed, including appropriate portions of my body, for medical, scientific, and educational purposes."

While far superior to the first, there is no suggestion that this form is flawless. It contains a number of medical terms not rendered in lay language (e.g., cardiac decompensation), describes the possibilities of success and failure only in the most general terms, and gives a far broader anesthetic authorization than is necessary. The form also fails to spell out clearly the experimental nature of the artificial heart and the probability of its both being implanted and functioning successfully. The wisdom of the court in Cooley's case was that Dr. Cooley told Mr. Karp orally that he had a 50-30 chance of surviving the ventriculoplasty operation.

The suit's allegations. Mrs. Karp's first allegation was that he did not understand how experimental this procedure was, and was not informed of the details of the animal testing. This argument was rejected by the court as irrelevant. The court noted that under the law only Mr. Karp, and not the power to consent to this surgery, and her consent was not only unnecessary, but would not have been legally valid while Mr. Karp was capable of giving consent. Her second argument, that her husband did not read the document, was also rejected by the court on the basis that Texas law (the law that this federal court had to apply to the case) required that the jury be instructed that Mr. Karp was charged with reading the consent document by the fact of his signature, even though he in fact did not. Her final major argument, and the one that both courts spent most of their time examining, was that Dr. Cooley did not give Mr. Karp sufficient information concerning the nature of the artificial heart for Mr. Karp to give valid informed consent.

It should be noted that the modern trend is to permit the jury to decide whether the amount of information given to the patient is sufficient for proper consent. The theory behind this rule, recently applied in California, Rhode Island, Wisconsin and the District of Columbia, is that: "The patient's right to make up his own mind should not be delegated to a local medical group." Rather, "the test for determining whether a potential peril must be divulged is its materiality to the patient's decision." (These cases will be discussed in a future column.)

Medical testimony's role. Texas law, however, follows the majority rule, which requires that expert medical testimony be introduced to demonstrate to the jury what a "reasonable medical practitioner" would have done in the same or similar circumstances. The requirement of medical testimony is based on the belief that without it the jury would be engaged in speculation and conjecture, and might set up their own standards of disclosure with no medical basis. In this case what was called for was testimony by a physician of expertise similar to that of Dr. Cooley. The only witness the plaintiff was able to produce on this subject was Dr. Michael DeBakey, and he refused to willingly testify in the case. After an examination in chambers, the judge refused to compel Dr. DeBakey to testify after DeBakey said he did not want to, would refuse to answer hypothetical questions, and had never examined Mr. Karp, and would refuse to give any opinions about the particular artificial heart used on Mr. Karp or the probable cause of Mr. Karp's death. Without testimony of Dr. DeBakey or someone with a similar expertise, the court followed the choice under Texas law but to direct a verdict in favor of Dr. Cooley on the issue of informed consent given the contents of the consent form signed by Mr. Karp.

It should also be noted that while this case involved a first human artificial heart experiment done with debatable pre-testing on animals and without formal peer review of protocol, these issues were not dealt with by the court. Indeed, the appeals
Kaleidoscope

Trustees gain insight from seminars on health-care issues

University Hospital trustees are being kept abreast of trends and issues in the health-care field by trustee-orientation seminars, a series of meetings that feature presentations from policy makers and health officials. The program is believed to be the first in the area.

The seminars were inaugurated by UH Administrator John H. Betjemann and John F. Cogan, Jr., president of the UH board of trustees, as a response to the changing roles of trustees. Said Betjemann, "Hospital trusteeship has changed dramatically in recent years, and our trustees have responded to the challenge in a forthright and positive way, starting with the desire to be maximally informed."

The program includes roughly a one-half hour presentation by the speaker and a half-hour of questions from trustees.

Cites Weiner talk. "By listening to the speakers," Cogan said, "the trustees can see more clearly the background from which proposals arise." As an example Cogan cites the historical background on health care that Steven M. Weiner, chairman of the Massachusetts Rate Setting Commission, presented when he addressed the trustees. "This gives us a better idea of how Weiner is perceiving the health-care industry today," Cogan said.

Paul F. Hellmuth, chairman of the board of trustees, also points to the benefits of face-to-face meetings with regulators and policy makers. "The seminars fill you in on the thinking that goes into public policy," said Hellmuth. "It's not the kind of thing you get from picking up a newspaper."

Bernashe next speaker. In addition to Weiner, speakers at these luncheon meetings during the past year have included: Jerald L. Stevens, secretary of human services; Jonathan L. Fielding, M.D., commissioner of public health; Robert Okin, M.D., commissioner of mental health; and David Kinzer, president of the Massachusetts Hospital Association. Senator Roger L. Bernashe (D-Chicopee), cochairman of the legislature's Joint Committee on Health Care, is scheduled to speak at the next seminar in October.

"The program is flourishing, and the trustees are looking forward to more of them," Cogan said.

Sandson is elected to HSA board

John I. Sandson, M.D., dean of BUSM, has been elected to the Board of Directors of the Health Planning Council for Greater Boston, the official Health Systems Agency for 65 Greater Boston communities.
The Health Planning Council, designed to strengthen participation in planning for new or improved health services in the Greater Boston area, is one of the first nonprofit agencies in the country to be named by federal officials as a Health Systems Agency under the National Health Planning and Resources Development Act.

Both Sandson and John H. Betjemann, University Hospital Administrator, have been elected to membership on the Central Metro Health Council, one of the five citizens’ groups advising the Health Planning Council. In addition, Betjemann was elected chairman of the central council by his fellow members.

Sandson was one of 12 health-provider representatives elected to the 30-member Health Planning Council board, which also includes 18 elected consumer representatives. The directors were elected by the membership of five metro health councils, which are citizens’ advisory groups sponsored by the Health Planning Council.

The board has overall responsibility for setting agency policies and directing the Council’s multiple planning, evaluation and educational activities. The Council’s duties include reviewing certificate-of-need applications, conducting studies on various health topics, and developing a comprehensive health plan for the Greater Boston area.

**SGD is chosen for unique nutrition education program**

Clinical experience will supplement the lectures in nutrition now given to D.M.D. candidates at the School of Graduate Dentistry, in a program currently being developed by Louis C. Fillios, Ph.D., professor of biochemistry and chairman of the Department of Nutritional Sciences.

The School of Graduate Dentistry is one of three dental schools in the country, and the only one in the Northeast, to receive a grant for advancing nutritional education in a D.M.D. program. “This HEW grant was designated for a special purpose,” Fillios said, “and I believe we can make a significant contribution in D.M.D. education through its use.”

Herbert Wells, D.M.D., assistant coordinator of the program, said he believes that this is the only course of instruction for dental students in nutrition to include practical experience of this nature.

**For deeper insights.** The program, being developed with the cooperation of the Clinical Nutrition Unit at University Hospital, will be offered to third- and fourth-year students. In this program, the students will have lectures on nutrition as well as participating in clinical rounds, to gain a better understanding of how nutrition affects patients with various diseases.

“We want to provide dental students with a deeper insight to nutrition, enabling them to be better oral physicians,” Fillios said. “They should be able to recognize the signs of a serious medical problem, or a problem that can be managed by diet.” The students will be instructed to look particularly for symptoms that may appear in the head and neck area, or that can be seen in a close view of the patient, as in a regular dental examination.

“These dentists will not be expected to treat such problems in the patient, but they will be able to identify a problem, and refer the patient to a specialist more capable of handling his or her needs,” said William Steffee, M.D., Ph.D., assistant professor of nutritional science at SGD.

“As well as placing emphasis on clinical nutrition as a legitimate medical entity, we will teach students to look for abnormal occurrences, like soreness of the tongue or loss of teeth, which could be signs of a vitamin deficiency and have a basis in malnutrition. Dentists will also be made aware of other symptoms, not necessarily in the mouth, such as cholesterol deposits in the eyes, which could be a sign of high fat content in the body, or be a warning signal of high cholesterol, and possible cardiovascular problems,” said Steffee, who is also director of the Clinical Nutrition Unit at University Hospital.

“As instructors, we will also stress the disease processes of metabolic disorders, such as diabetes or cancer, and the way in which these problems are treated or controlled by correct diet,” he added.

**More challenging.** Students will be provided with 45 hours or more in nutritional science and clinical exposure, according to Fillios. “In the past, dental students were taught by lectures and slide demonstrations. This new program is designed to be more intensive than any course in nutrition that the School has previously had,” Steffee said. The directors of the program feel that this new curriculum will be more challenging, especially since it now involves actual patient examination.

“This is a sensible way to present the study of nutrition,” said Fillios. “It’s definitely more comprehensive than current courses of study offered, and we feel that the School’s graduates will be more complete dentists because of it.”

**M.D., Ph.D. offered in new combined degree program**

Highly qualified students who wish to prepare for a career that may combine clinical practice with medical research can now receive both the M.D. and Ph.D. degrees in a formal combined degree program offered under the joint auspices of the School of Medicine and the Boston University Graduate School.

In the past, according to Ruth R. Levine, Ph.D., chairman of the Division of Medical and Dental Sciences, a small number of students have earned both degrees under an ad hoc arrangement that permitted them to register separately in the two schools and work on the degrees concurrently. (The Division of Medical and Dental Sciences is a division of the Graduate School that incorporates the M.A. and Ph.D. programs of the School of Medicine and the School of Graduate Dentistry.)

**Will register jointly.** Under the new combined-degrees program, approved by the Academic Programs Committee in May, candidates will apply and register jointly for both degrees. In addition, while it is expected that they will usually choose to earn the Ph.D. degree in one of the basic medical sciences, as was required under the ad hoc program, they may also choose one of the other natural sciences—such as biology, chemistry or physics—and even disciplines more broadly related to medicine, such as politics, economics, philosophy, psychology or history.
Three students already working toward the two degrees under the ad hoc program have been admitted to the new program, Levine said, and another student has been admitted to begin work this fall. The program will require from five to seven years of study.

**Earned M.D., Ph.D. in 1925.** Records show that a BUSM student first earned both the M.D. and Ph.D. degrees in 1925, and that eight School of Medicine students have done so in the past 10 years. Several years ago, according to Levine, a student in the Six-Year Program received the B.A., M.D. and Ph.D. degrees all on the same day.

Applications for admission to the combined degree program may be obtained from the Admissions Office of the School of Medicine.

**Five elected UH trustees**

Four men and one woman, all leaders in their fields, recently were elected trustees of University Hospital.

They are Judge Harry J. Elam, Dorothy C. Keefer, Alexander Rodriguez, Melvin I. Shapiro and George E. Slye.

Harry J. Elam, associate justice of Boston Municipal Court, is chairman of the board of directors of the Elma Lewis School of Fine Arts. Elam is also a trustee of the Noble and Greenough School and a past president of the Urban League of Greater Boston.

Judge Elam is a graduate of Boston University and Boston University School of Law.

Dorothy C. Keefer, president of the University Hospital Aid Association, has been registrar of the School of Medicine since 1970. She has held various administrative positions at University Hospital and the School of Medicine since her graduation from Boston University.

Keefer is the widow of Chester S. Keefer, M.D., former dean of BUSM. She is a member of the Charter Committee of the Friends of the Boston Medical Library and is a member of the Friends of the Libraries of Boston University.

Melvin Shapiro, a lawyer and certified public accountant, is a partner in the Brookline accounting firm of Toflas, Fleishman and Shapiro. His professional affiliations include the American Institute of Certified Public Accountants and the American Association of Attorneys-Certified Public Accountants.

Shapiro received his law degree from Northeastern University School of Law. He also studied at the University of Virginia and the University of Chicago.

George Slye is executive vice-president for development of Spaulding and Slye Corp., a Boston-based real estate development company. He is currently a director of the Greater Boston Real Estate Board, a director of the Big Brother Association in Boston and president of Boston's Rental Housing Association.

Slye received his undergraduate degree from Wesleyan University and a master's in business administration from Babson College.

Alexander Rodriguez, a leader in the Hispanic and Greater Boston communities, is assistant executive vice-president of the United Community Planning Corp.

The recipient of numerous leadership awards, Rodriguez was chosen in 1971 as one of 10 outstanding young leaders in Boston by the Boston Junior Chamber of Commerce. He is a corporator of UH and is a graduate and treasurer of Goddard College. He did graduate work at Indiana University and Harvard University.

**Radiology Dept. donation honors Dera Kinsey Ruegg**

An angiographic reading area was donated to University Hospital's Department of Radiology this summer by Isabella Grandin in honor of her longtime friend and physician, Dera Kinsey Ruegg, M.D.

Dr. Ruegg joined the staff of Massachusetts Memorial Hospitals (now University Hospital) just after World War II and was active in internal medicine until her retirement in 1973.

During that time, she worked with Reginald H. Smithwick, M.D., now on UH's consulting staff in surgery, in her special interests — hypertension and cardiovascular disease.

"It gives me great pleasure to make a contribution to this hospital in honor of such a dear person, my friend, Dr. Dera Kinsey Ruegg," Grandin said.

At a reception held in the Wilkins Board Room to honor the two ladies, Ernest J. Ferris, M.D., chief of diagnostic radiology at UH, thanked Grandin for her generosity. After the reception, Ferris led a brief tour through the reading area, marked with a plaque recognizing Grandin and Ruegg, and also showed the guests the Hospital's angiographic equipment.
Hospital employees honored for length and quality of service

Nearly 200 University Hospital employees received length-of-service awards or special awards at the third annual UH service-recognition ceremony in June. The event marked the beginning of the Hospital's annual Employee Week.

Honored for 45 years of service was Helen Foley, R.N., nursing director for Ambulatory Services. Awards for 25 years of service went to Herbert D. Klein, administrator for Plant Services; Jennie Skipper, of the Cart Distribution Center; and Elizabeth Manning, R.N., who recently retired.

Ten employees were recognized for 20 years of service, 17 employees for 15 years, 17 employees for 10 years, and 137 employees for five years. Hospital president John F. Cogan, Jr., presented the awards.

Honored at dinner. The employees with the longest terms of service were guests of honor at a recognition dinner the night of the ceremony.

In the special-awards category, Jim Toro, Housekeeping director, received the "80-Hour Plus Award" for hard work and long hours. The "Friendly Award" went to Al Fontes, orderly in Nursing, who was described by Hospital Administrator John H. Betjemann as "terrific with the patients and terrific with the staff."

UH Controller George Major was presented with the "Super Boss Award." "George symbolizes what it means to be a good boss," said Betjemann. The "After Midnight Award," for excellent service on the night side, was presented to night Nursing manager Phyllis Davis, R.N. Robert Berger, M.D., chief of cardiothoracic surgery, received the "Super Doc Award."

"Hospital has stayed strong." In a speech to the near-cadency crowd gathered in Keefer Auditorium for the ceremony, Richard H. Egdaahl, M.D., director of the Medical Center, hailed the many ongoing programs that have been developed at the Hospital, calling their success "a tribute to so many of you who have been involved."

Egdaahl referred to the frequent changes in leadership that have taken place at the hospital in recent years, and said, "Despite these changes, the Hospital has stayed strong. The administration has worked with key people—many of you here today."

Employee Week activities also included two barbecues—one for daytime employees and one for evening and night-shift employees—and a midnight cruise of Boston Harbor.

Workshops to explore media in education

A series of workshops entitled "Production of Learning Resources," designed for occupational therapists, physical therapists and registered dietitians, will be offered in the fall and winter at the Sargent College of Allied Health Professions.

The workshops are divided into two sessions: "Slide with Synchronized Tape," Sept. 27 to Nov. 29; and "Portable Videotaping," Feb. 14 to April 18. They are intended primarily for health professionals currently in faculty or administrative positions in post-secondary institutions or clinical facilities, who want to learn to apply the concepts and techniques of educational media in health and educational settings.

BUSM introduces part-time M.P.H. degree program

Boston-area professionals in health care and related fields will be able to earn a master of public health (M.P.H.) degree part-time, while continuing to work in their present jobs, in a new evening program being introduced by the School of Medicine this fall.

The part-time program will be the only one in the Boston area offering the M.P.H. degree at night, and among only two or three exclusively evening programs in the entire country. In Massachusetts, Harvard University and the University of Massachusetts at Amherst are the only other schools offering the M.P.H., and theirs are day programs.

Designed for professionals. In making the announcement, Dean John I. Sandson, M.D., said the program is designed for persons already employed as professionals in health and related fields, such as nurses, physicians, allied health professionals, lawyers, dentists, administrators and others. Most students accepted into the program will already have a graduate or professional degree in a health or related discipline, Sandson said.

Approximately 50 persons were accepted into the program this summer, to begin classes in September, according to Douglas Decker, Ph.D., the program's associate director. Decker said more than 1,600 requests for application forms were received in response to a preliminary announcement of the program released last spring to health institutions in the area.

Response to rapid changes. Decker described the pioneering new program as partly a response to recent rapid changes in the health-care system, which have placed new demands on people in the health professions. He cited the advent of extensive federal and state regulation of health care, and the rise of such issues as medical liability, bioethics, and the safety of drugs and other medical treatments.

"The program will help health professionals acquire new skills to keep up with the changes in the field, while continuing their careers uninterrupted," Decker said.

Candidates for the M.P.H. degree must complete 12 four-credit courses and in most cases will take three years to complete the degree. Students will take two courses each semester, attending classes two evenings a week.

To choose concentration. All students will take required courses in epidemiology, biostatistics, health planning and administration, and behavioral science. In addition, Decker said, students will be expected to concentrate in either health administration or health research and evaluation.

The program is administered by the School of Medicine Department of Socio-Medical Sciences and Community Medicine, and Norman A. Scotch, Ph.D., chairman of the department, is program director. Courses will be taught by faculty from throughout the University, from such schools as Law, Management, the Graduate School of Arts and Sciences, and Sargent College of Allied Health Professions.

Classes will be held at the University's Charles River Campus.
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University Hospital's model for America

The New England Regional Spinal Cord Injury Center of University Hospital has been designated a model demonstration project for regional spinal-cord injury programs throughout the country by the Rehabilitation Services Administration of the U.S. Department of Health, Education, and Welfare.

The announcement was made in Washington, D.C., by Sen. Edward W. Brooke, who said University Hospital's unit would be a "unique facility in New England, offering those suffering spinal-cord injuries the fastest and best possible care."

Three-year award. The designation, which brings with it an award of $250,000 annually for three years, will enable the Regional Spinal Cord Injury Center to establish a model multidisciplinary treatment program to address the total medical, physical, vocational and emotional needs of the spinal-cord injured person. The grant also will allow the Center to train professionals in optimal care for spinal-cord injured persons as well as to provide others in the field and members of Congress with patient-care and cost-effectiveness information.

University Hospital was the first nonmilitary general hospital in the United States to offer comprehensive treatment for spinal-cord injury. A unit for specialized care was opened in 1955 under the direction of the late Donald Munro, M.D., world pioneer in the care of the spinal-cord injured.

The Center is the only separate general hospital unit in the Northeast devoted solely to the care of spinal-cord injury. The Center provides immediate care, ongoing care and lifetime follow-up, to all spinal-cord injured persons regardless of medical-care sponsorship.

Murray M. Freed, M.D., chief of rehabilitation medicine at University Hospital, is director of the Center. Freed, who is also professor and chairman of rehabilitation medicine at the School of Medicine, emphasized the total needs of spinal-
cord injured persons, as mandated by the award.

"It's not enough to enable the patient just go out the door of the hospital. He has to function in the community, and for this he needs help in such things as being 'accepted' and getting rid of architectural barriers."

**Job and school records exemplary.** The vocational and academic records of spinal-cord injured persons are exemplary, Freed said. "They do excellent work in an appropriate field with an appropriate physical set-up."

A team of University Hospital medical specialists aids in the treatment of spinal-cord injured patients. It includes two neurosurgeons, a urologist, general surgeon, neurologist, orthopedist, plastic surgeon, psychiatrist, as well as internists with special interests in infectious diseases, pulmonary medicine, vascular disorders and joint diseases. Other health professionals include a rehabilitation nurse, social worker, psychologist, bioengineer, occupational and physical therapists and recreational personnel.

Recent statistical studies place the incidence of new spinal-cord injuries in the United States at 8,000 to 10,000 annually. The incidence has grown over the past few years, largely due to the increased number of motor-vehicle accidents. Within that category, motorcycle accidents are the fastest rising in number. Spinal-cord injury may also result from industrial accidents, such as falls or direct blows to the back; and sports accidents, particularly diving.

Most commonly, paraplegia and quadriplegia—paralysis of the legs and/or trunk, or the arms, legs and trunk, respectively—have their onset in males aged 15 to 40, since they comprise the group most likely to be involved in such high-risk activities. At the University Hospital Center, the average age of the spinal-cord injured patient is 24. Although men are the most susceptible to spinal-cord injury, about 10 percent of the Center's population are women.

The Center will establish guidelines for the care of spinal-cord injuries from the moment of injury through acute medical care, rehabilitation and lifetime follow-up. The importance of early detection of physical and emotional complications will be emphasized.

**Data-gathering.** The Center will also develop normative and epidemiological data on spinal-cord injured persons. One aspect of the epidemiological data will be to determine whether spinal-cord injured persons are affected by certain diseases earlier than the general population. "As spinal-cord injured persons approach normal longevity, they are prone to the same diseases that affect the general population—heart attack, cancer and stroke," said Freed. "We want to learn whether they are subject to diseases earlier because of problems associated with spinal-cord injury." The normative data will include such information as normal blood pressure for the spinal-cord injured, which is different from that for the able-bodied population.

The Center will combine its confidential data with those collected at the 10 other model spinal-cord injury centers across the country, Freed said.

The other model demonstration projects for regional spinal-cord injury systems are located in Alabama, Arizona, California, Colorado, Illinois, Minnesota, New York, Texas, Virginia and Washington.

An important part of the comprehensive treatment program, Freed said, is skilled evacuation from the accident site. Freed anticipates close cooperation with Linda Leddy, director of the Massachusetts Office of Emergency Medical Services, to assure the best methods of evacuation for the spinal-cord injured.

**Help from Advisory Council.** The Center’s six-member Advisory Council, composed of paraplegics and quadriplegics, counsels Freed on matters related to spinal-cord injury. Elmer Bartels, of Bedford, president of the New England Spinal Cord Injury Foundation, is a member of the Council. The Center and Foundation will continue to work together to foster improved patient care and education programs to prevent spinal-cord injury.

The Council’s one female member, Eileen McNamara, talks with all women who enter the Center. She is chief technician in renal physiology at Boston University School of Medicine.

Commenting on the award, Sen. Brooke said, "As a ranking member of the Labor-HEW subcommittee of the Senate Appropriations Committee, I fought very hard to see that $250,000 was earmarked in this year’s appropriations for spinal-cord injury rehabilitation. I am very happy to see that the New England Regional Spinal Cord Injury Center has been the recipient of this federal money."

Susan Gertman

A related article on technological advances for the spinal-cord injured appears on page 18.
A boost for home care in Boston

by Susan A. Gertman

George Rosenthal, M.D., and Judith O'Grady, R.N., of University Hospital's Home Medical Service, climb four flights of darkened, glass-strewn stairs to reach the apartment in Boston's South End of their patient, 84-year-old Agnes McCarthy.* Mrs. McCarthy, who has to lean against furniture to steady herself, opens the door, embraces O'Grady and squeezes her cheek. "It's wonderful to see you," she says, inviting them inside.

Rosenthal examines Mrs. McCarthy's leg, red and swollen from leg ulcers, and listens to her heart. O'Grady asks about her health, what she eats and how she has been spending her time. Their conversation is nearly drowned out by the rumble of a passing train that regularly travels down the elevated trolley tracks a few yards from her window.

Two weeks after the Home Medical Service team completes its bimonthly visit, a nurse from the Visiting Nurse Association of Boston also comes to the South End apartment to examine Mrs. McCarthy and teach her how to care for her leg ulcers. In between visits, Rosenthal and O'Grady talk with the visiting nurse about Mrs. McCarthy's medical problems, her declining ability to care for herself and the possibility of finding her an apartment in an elderly-housing unit.

*Not her real name

Medical care for hundreds of elderly residents of South Boston and the South End has been strengthened by an alliance of two of Boston's oldest health-care organizations, agencies with the rare mission of caring for the sick at home—the University Hospital Home Medical Service and the Visiting Nurse Association of Boston.

On July 1, the Home Medical Service and the South End/South Boston branch of the Visiting Nurse Association moved into a suite of offices in the Doctors' Office Building on the Medical Center campus. (The Home Medical Service, a part of University Hospital's Outpatient Department, also treats elderly residents of the Back Bay.)

Dorchester, Fenway and Roxbury sections of Boston, where it works with other VNA branch offices).

Communication through sharing. Shared office space will facilitate communication, continuity of patient care, access to patient records and educational conferences, said Alice Dempsey, R.N., general director of the VNA of Boston. "I really think this will bring the best of both services to the patient."

This unique association between two home-care agencies is achieved through shared objectives, education and cooperation, not by means of a charter. There is no legal tie between the two organizations.

"The VNA and HMS complement each other," said Anna Bissonnette, R.N., HMS director of patient care and assistant professor of community medicine at the School of Medicine. "When communication breaks down, continuity of patient care suffers."

In addition to nursing care, the 90-year-old VNA provides physical, occupational and speech therapy; medical social-work; nutritional services; and homemaker/home health-aide service.

It spells an important difference. The combination of physician, nursing and homemaker services offered by the HMS and VNA often spells the difference between hospitalization and placement in a nursing home for many patients.

Sr. Rosemary, a member of the Sisters of Charity and coordinator of a clinic at Unity Tower in the South End (one of six housing units for the elderly and handicapped served by HMS and VNA), said several tenants would have had to be institutionalized if it were not for these services. She cites two examples:

—an 84-year-old woman with circulatory problems and general physical and mental deterioration brought on by old age, who is followed regularly by HMS and has a homemaker/home health-aide provided by the VNA;

—a 63-year-old terminal cancer patient who is treated regularly by the HMS and VNA and has a VNA homemaker/home health-aide who helps his infirm wife care for him.

Many tenants in these housing units are ambulatory, but
they are emotionally unable to deal with appointments, travel to the hospital or to wait to be examined, Sr. Rosemary said. "Many tenants with medical problems hadn't seen a doctor in years before the Home Medical Service opened here."

According to Sumner Hoffman, M.D., director of HMS and professor of community medicine and socio-medical sciences at the School of Medicine, many barriers prevent the elderly from taking advantage of the traditional systems of health care. Often they are too infirm to leave their apartments, they are afraid to leave, or they do not know that certain support services, such as transportation, are available.

A community-oriented nurse. Brown said, has to develop good interviewing and observation skills. "She has to ask herself, 'Are these patients getting the services they want and they need?'" And, because the visiting nurse takes the time to develop a relationship of trust with the patient, she may succeed in treating a patient where others have failed, Brown said.

Brown emphasizes what she calls the difference between "task-oriented" and "community-oriented" nursing. When a task-oriented nurse is instructed to change a dressing, Brown explained, she goes to the home, changes the dressing and leaves, whereas the community-oriented nurse changes the dressing, instructs the patient or a family member on hygiene, teaches a family member to give the patient care, and, if there are young children at home, asks if they have been immunized.

Building a relationship. A community-oriented nurse, Brown said, has to develop good interviewing and observation skills. "She has to ask herself, 'Are these patients getting the services they want and they need?'" And, because the visiting nurse takes the time to develop a relationship of trust with the patient, she may succeed in treating a patient where others have failed, Brown said.

The visiting nurse reports to the referring physician at least every two months, or as often as necessary. Members of the HMS and VNA make joint home visits when the patient's condition has changed and a different medical regimen is called for, or if the nurse cannot treat the patient herself.

"We cannot prescribe a medical regimen," Brown said. "The

Most of HMS's 500 active patients are between 75 and 100 years old. Some patients are seen daily at home during acute illness as an alternative to institutional care. However, HMS physicians do admit and care for patients in the hospital, and they recommend hospitalization when they think it is in the patient's best interest.

The patient changes. "Nearly everyone, but especially the elderly, takes on a different character in the hospital," Bissonnette said. "A patient becomes more dependent, and deterioration occurs. . . . We try to get people back into their homes and help to keep them there with home-care services."

Carl Ollivier, the HMS social worker, attends to the "nitty-gritty details" of maintaining patients at home. He works with other social service personnel to arrange discharge plans for all HMS inpatients. He orders equipment, such as walkers, and assists with referrals for VNA and homemaker services.

"In making these arrangements for patients," Ollivier said, "we always have to consider whether the patient has reached the point where he can no longer be maintained at home with the resources available." If a patient cannot be supported at home, Ollivier helps arrange chronic-hospital or nursing-home placements.

HMS treats three categories of outpatients: acute care patients who would be hospitalized if it were not for HMS and VNA services; chronic maintenance patients, such as those with arthritis, malnutrition or heart disease; and health-maintenance for those who are examined in one of the six elderly-housing units served by HMS.

When a patient moves from the hospital to the community, there is a change in who has control, said Nancy Brown, R.N., supervisor of the VNA's South End/South Boston district. "When the patient is in the hospital, the health-care professional makes all the decisions," she said. "When he is in the community, the shoe is on the other foot. You cannot control his alcohol, you cannot control his diet and you cannot force him to take his pills."

The South End/South Boston VNA district usually has between 400 and 600 patients, 30 percent of whom are under long-term care.

Brown emphasizes what she calls the difference between "task-oriented" and "community-oriented" nursing. When a task-oriented nurse is instructed to change a dressing, Brown explained, she goes to the home, changes the dressing and leaves, whereas the community-oriented nurse changes the dressing, instructs the patient or a family member on hygiene, teaches a family member to give the patient care, and, if there are young children at home, asks if they have been immunized.
Shared office space facilitates impromptu case conferences. Here Glennon and Rosenthal review a patient's record.

patient has to be under a doctor's care, but we do a lot with preventive medicine, health teaching, and hygiene on our own."

HMS is supported in part by the School of Medicine as a vehicle for teaching fourth-year students about the elderly, community resources and home care. "It is not unusual for a 90-year old to manage at home with supportive services," said Bissonnette, "and it's important for medical students to see this, so when they treat the elderly in the hospital, they will know about community home care resources and think to send the patient back home instead of to a nursing home."

It is difficult for a patient to buck the system alone, Bissonnette said. Most patients want to stay at home, she said, but if they have no family, and the hospital staff recommends a nursing home, they usually end up going.

During the required four-week rotation through HMS, fourth-year students spend five hours daily with patients, one hour in case conferences and one hour in formal teaching sessions. Lecture topics include management of medical problems at home; legal aspects of home care, including accountability in delivery; protective services; financing health care; nutrition; and community programs. A representative of the Massachusetts Department of Public Welfare teaches the students how to make maximum use of public assistance.

What students gain. "We are trying to teach the student to recognize the needs of the individual, both socially and economically, and to be cognizant of the resources available to meet these needs, as well as to know about geriatric medicine," Hoffman said. The rotation also makes the student aware of environmental problems, such as inadequate heating, faulty plumbing, flies and roaches, that impinge on the general welfare of the patient. This aspect of community health is taught by Hoffman, who holds a master's degree in civil engineering and environmental health.

"A really good aspect of the course is that we learn about what community resources are available to treat the patient at home," said Andrew Berezin, a student from Newton, Mass. "Some students didn't know the VNA existed before they took this rotation."

Michael Dern, a student from New York City and a 1973 graduate of the College of Liberal Arts, said he has a better understanding of the neighborhood surrounding BUSM since he began his rotation. "I've learned that there are sick, lonely people who cannot get to a medical center, but who need support, medically, therapeutically and emotionally. And, I've learned how to integrate the VNA and homemakers along with Home Medical. . . We're all working for the same purpose, and that is to give medical and emotional support to the patient."

The students examine patients at home and in clinics under the supervision of one of the three physician-preceptors.

A cooperative agreement drawn up between the two home care agencies calls for the VNA to participate in student education. "I feel that we have a role, too, in helping students administer care in the community. Part of it is taking the environment into consideration," Brown said.

'It's a happening.' "Many of our nurses have a high level of proficiency in administering health care in the community, and I think they have something to teach the students," Brown said.

Bissonnette, who holds a master's degree in nursing from the School of Nursing, added, "It's unique for doctors and nurses to sit down and work together—it's a happening."
Quadriplegic patients control surroundings with electronic device

Quadriplegic patients in the New England Regional Spinal Cord Injury Center at University Hospital are learning to do what was once impossible for them: control their surroundings independently.

By using an environmental control unit manufactured by Prentke Romich Co., a person paralyzed from the neck and shoulders down can switch on lights, draw curtains, flip on a radio or "dial" a friend on the phone. All of these things can be done either by a quick intake and puff of air or by pressure and puff of a single lever.

**Simple to operate.** Although the device looks complicated, it is actually simple to operate, said Lois Siegleman, R.P.T., chief of physical therapy at UH. "A person can learn to use the control unit in about five minutes," she explained. Physical and occupational therapists teach patients in the Spinal Cord Injury Center to use the equipment.

Commenting on the impact of the environmental control unit, Murray M. Freed, M.D., chief of rehabilitation medicine at UH, said, "Because anything motorized can be attached to the equipment, the kinds of independence the unit affords the patients, both in the hospital and at home, is extremely important in patient care and rehabilitation."

Not only does the unit provide the patient with more personal freedom, Siegleman explained, but it also allows the professionals in the Center to concentrate more on providing actual health care.

The unit, about the size of a large table radio, is a metal box containing 12 sockets. One electrical appliance, such as a television set or lamp, can be plugged into each socket.

Connected to the box through a series of wires is a smaller unit called the scanner display. This display unit is attached to the frame over the patient's bed and positioned so that the person can easily see it.

On the face of this unit is a series of lights; one corresponds to each of the sockets in the tabletop control unit. In setting up the unit, the therapist labels each light so the quadriplegic knows, for instance, which station controls the radio and which activates the draperies.

**Run by pneumatic device.** The patient operates the unit by a pneumatic device hooked directly into the overhead scanner. A gooseneck tipped with a small mouthpiece extends from the display panel to a point within easy reach of the patient's mouth.

When the patient wants, for example, to turn on the radio, he will take the tube in his mouth and suck. This sucking illuminates each red bulb on the scanner display in sequence. A distinct click also sounds as each successive light comes on. When the display panel light labeled "radio" lights, the patient blows to switch on the radio. If he then wants to switch on the light, he'll suck again, or track, until the scanner is at the right station, and then puff. To turn off the light or radio, he simply repeats the process.

For some patients, therapists choose a tongue switch or a rocking lever (activated by pressure of any moveable part of the patient's body, such as the chin, shoulder or head) instead of the pneumatic device to track on the unit.

"The speed of the tracking of the display panel can be adjusted for each patient," said Susi Wepman, O.T.R., assistant chief of occupational therapy at UH. "We start out slowly until the person gets the hang of it, and then we increase the tracking speed as he becomes more proficient."

**Unit for phone-dialing.** The Hospital's unit also includes the optional telephone-dialing device, which hooks into the main unit and operates on the same basic tracking principle. The patient tracks to the telephone station on the overhead scanner, and the dialing unit is automatically activated. Watching a digital readout (which is also augmented by audible clicks) on the telephone unit, the patient blows until he reaches the first digit in the phone number. When he reaches that number, he stops blowing, the readout returns to zero, and he's ready to dial the second digit. A second gooseneck holds the receiver of the phone.

Therapists teach the patients how to use the equipment so they will be able to operate their own unit at home after discharge from the Hospital.

"The unit could be on a table in the patient's home, with the gooseneck of the pneumatic switch at a certain height, said Nancy Dutton, R.P.T., physical therapist at UH. "Using an electric wheelchair operated by a chin control, the quadriplegic could wheel right up to the unit, take the switch in his mouth and control his entire environment," she continued.

"It really provides an amazing amount of freedom for both the patient and his family." Nancy Haslam
Thomas Royle Dawber heads for retirement —again

Heart study’s chief architect and leader in MRFIT plans one more big caper

When Thomas Royle Dawber, M.D., M.P.H., announces he’s going on a caper, he doesn’t mean a holdup or a jewel robbery. He often excuses himself to “go off on a caper,” which means he’s about to dive back into one of the projects that have made him a leader in coronary heart-disease research.

This summer, Dawber curtails some of his activities preparatory to retiring from the School of Medicine. He’ll devote most of his time to writing a monograph summarizing nearly three decades worth of Framingham Heart Study data on atherosclerosis, the leading killer of Americans.

27 years with heart study. Dawber, professor of medicine at BUSM, is best known for his dedication to the Framingham Heart Study. For 27 years, 18 of them as chief administrator, he involved himself in every aspect of the project — clinical exams, laboratory tests, preparation of data, write-ups, administrative duties. Data collected at Framingham under his leadership have contributed significantly to public awareness of the three salient risk factors in heart disease and stroke — high blood pressure, cholesterol, and cigarette smoking.

Dawber is also co-investigator with BUSM’s H. Emerson Thomas, M.D., on the Medical Center’s MRFIT (Multiple Risk Factors Intervention Trial) program, which seeks to discover whether it is possible to lower the incidence of heart attack and stroke by reversing the risk factors. He participates in a study in Yugoslavia supported jointly by the National Heart and Lung Institute and the Yugoslavian Federal Institute of Public Health. The study is conducted in a way similar to the Framingham study, but in Yugoslavia the data are being collected from a population with a low incidence of atherosclerosis. It is hoped the data will explain why Americans suffer more atherosclerosis, on the average, than their Yugoslav counterparts.

And in yet another project, the Veterans Administration’s Normative Aging Study, Dawber observes healthy veterans as they age. The study, which has no time limit for completion, has been surveying veterans of World Wars I and II and the Korean and Vietnam conflicts for 10 years. Dawber
hopes to learn what happens to blood pressure and cholesterol levels as people get older, provided no disease causes them to change.

'Retirement' a matter of definitions. Retirement doesn't come naturally for Dawber, who can't seem to put aside the active career he's pursued since graduation from Harvard Medical School in 1937. He "retired" from the Framingham Heart Study 10 years ago to take a position at BUMC, though he is still involved in the study. Colleagues don't expect Dawber's BUSM retirement to put an end to his activities here; retirement for Roy Dawber seems to mean keeping one finger in the pie you've already tasted while sticking another finger into a new pie. He says that by the time he finishes the Framingham monograph in a year or two, he'll be ready to retire to his custom-built home in Naples, Fla.; he doesn't mention, however, that he has acquired a license to practice medicine there.

Roy Dawber's affiliation with the Framingham Heart Study began in 1949, when after 12 years of clinical medicine for the Public Health Service, he requested an assignment in research or public health work. Cassius J. Van Slyk, first director of the National Heart Institute, responded with an opportunity to create and implement a long-term study of heart disease.

The Institute had already encountered difficulties in locating for study a suitable population, one which contained a medical community receptive to the project. It ultimately selected Framingham, Mass. Van Slyk was also looking for a physician with both administrative skills and clinical training, a person who would command the respect of local physicians cooperating with the study. In this there was little trouble. Dawber fit the bill.

Takeover feared. "A lot of people don't understand the atmosphere that existed in 1949," Dawber says of his first days with the study. "The AMA and state medical societies were fearful of socialized medicine. There was talk of national health insurance even then. It's hard to believe how small the government was then compared to now, and yet doctors were very fearful that the federal government was going to take over medicine."

The Framingham study was one of the first to observe characteristics that contribute to a higher probability of heart disease. He was about to take a post at the Center for Chronic Disease Control in Atlanta when he foresaw that penicillin would drastically change the communicable-disease picture. He predicted that the public-health problems of the future would involve chronic, not infectious, disease.

No guarantees of positive results. But Dr. Dawber and William B. Kannell, M.D., another Public Health Service physician who has been with the study almost as long as Dawber, overcame such obstacles and designed an epidemiological approach to the task. "At the time, there wasn't any guarantee that what we were investigating was going to turn out positive," Dr. Dawber remembers. "In other words, if everything we had decided to investigate turned out not to be related to heart disease, this whole thing would have been a failure and folded up."

"But I thought the hypotheses were pretty good, and I suspected that some of the assumptions would turn out positively. We tried to think of the various things that could possibly be related to coronary disease and atherosclerosis and to make measurements of these things in the population."

By 1957, after four years of clinical follow-up on the population, some of the theories began to pan out. It became apparent that people who got heart attacks — there were 40 of them in the Framingham study population by 1957 — were different from the rest of the 5,000 subjects, particularly in terms of their cholesterol and blood-pressure levels. It was as yet too early to determine the effects of smoking, since the population did not include enough non-smokers to make their rate of disease statistically significant in relation to smoking. Year after year, researchers continued gathering information on the same observations, correlating the data also with stroke, eye disorders, and gall-bladder disease. Soon, the characteristics that contribute to a higher probability of heart attack and stroke would be widely known as the "risk factors." Many Americans would switch to vegetable oil margarines, the U.S. Surgeon General would issue a warning to be printed on cigarette packs, and physicians would realize the importance of recommending anti-hypertensive programs for their patients.

Not a mystery any more. "Why people get heart attacks was not a mystery any more," says William Castelli, director of laboratories for the study. "We pointed out the horrible epidemic of heart disease. Every fourth to eighth man in the study had a heart attack, depending on his age group. We've learned to identify heart attack victims 10 years before their attacks by looking at the cholesterol and blood sugar levels, blood pressure, ECG, etc. Now we don't have to sit around and wait for people to get heart attacks and strokes."

The Framingham study also became a prototype for the application of classical epidemiological techniques to the study of chronic disease. Dawber pioneered this epidemiological thrust, perhaps because he came close in his pre-Framingham days to entering the field of infectious disease (the previous major area of epidemiological methodologies) and recognized epidemiology's relevance to chronic disease. He was about to take a post at the Center for Disease Control in Atlanta when he foresaw that penicillin would drastically change the communicable-disease picture. He predicted that the public-health problems of the future would involve chronic, not infectious, disease.

Dawber's leadership in modern epidemiology and coronary disease risk factors elicits great praise from his colleagues. They call him the chief architect of the Framingham study, without whom it could not have succeeded as well, an innovator, a stimulator.

Not a traditionalist. "It's through his efforts and foresight that we've made the progress we have," says Kannell, who joined the Framingham study in 1949, fresh out of his in-
ternship. "He's not a traditionalist. He's open minded about new ideas. He believes that progress is made by people who go against the mainstream, the innovators that come under fire but are often shown to be correct."

"I can't imagine a better working relationship," agrees H. Emerson Thomas, M.D., Dawber's co-investigator on the Framingham study and MRFIT. "He is completely supportive and affirmative. His philosophy of leadership is to establish a task, put people in a position to carry it out, and to leave them alone to accomplish it, as long as the job gets done. He is able to assess the talents of his colleagues, and they have respect for him. They respond well in their work because of this respect, loyalty, and positive desire to achieve."

Dawber sets a fine example for young physicians, says Castelli. He considers suggestions from all parties, "even if he knows you're dead wrong. He gives you enough rope to hang yourself while he watches you learn from your mistakes."

"He imbues the attitude that the patient is the most important person and is doing us a favor by consenting to be studied. He believes they shouldn't be kept waiting, that we should accommodate them. This is quite a change from some clinical experiences I had where the doctor was the most important."

"He also teaches that you don't predetermine data; you wait to see how it comes out. He's eminently fair about carefully collecting data and not taking sides on it. He teaches patience, which is necessary when it takes you five to 10 years to prove some of your hypotheses."

From PHS to Evans. In 1966, Dawber had been in the Public Health Service for 28 years and had wartime credits giving him a total of more than 30 years of service. He announced his retirement from the Framingham study, and Kannell became director. Robert N. Wilkins, M.D., then chairman of the Division of Medicine and Wade Professor at BUSM, offered him a position in the Evans Memorial Department of Clinical Research. Lewis H. Rohrbaugh, then director of the Medical Center, simultaneously named him assistant to the director of the Medical Center, responsible for revising site plans for the Center and guiding its physical and program development. The position at the Evans entailed establishing an institute of preventive medicine; Dr. Dawber helped found the Boston University Cardiovascular Institute, which this year received a $4.5 million grant from the NHLI to study the causes, treatment and complications of hypertension.

During this time of supposed retirement from the Framingham study, Dawber, naturally, remained involved. In 1970, when the federal government changed its priorities and deemed clinical evaluations of the study population no longer valuable, and thereby discontinued its funding, Dawber initiated a highly successful fund-raising campaign, feeling it would be disastrous to stop collecting data. Support from foundations, trusts, insurance companies, individuals, and the American Tobacco Institute kept the evaluations in operation until 1974, when the NHLI reversed its decision and resumed support of clinical surveillance.

An important assist. Essential to the fundraising drive was Bette Hawes, who was Dawber's administrative assistant during his tenure at BUMC, retiring this past June. The work at BUMC was her second career, also. She had been a classmate of Dawber's wife, Eleanor, at Simmons College, in Boston, and had previously taught English. "She kept Dr. Dawber in line," reports Dr. Rohrbaugh, "and she wrote the best English at the School of Medicine."

Eleanor Dawber worked as a nutritionist at Tufts-New England Medical Center until her retirement last year. The Dawbers have two children, John and Nancy, who is a 1969 BUSM graduate.

Mrs. Dawber shares many domestic projects and a sometimes-eccentric sense of humor with her husband. The two have, at times, and for no particular reason, owned up to five automobiles. One, a Rolls Royce Silver Cloud nicknamed "Baby," carries them to the dump or the supermarket. They choose their Toyota for most of the serious driving. Dawber enjoys cars and driving, and he motors regularly to their home in Florida. He dislikes flying as much as he enjoys driving, and will drive 1,000 miles to avoid a plane trip. He once drove to Memphis to deliver a lecture, then turned right around and drove home.

The Dawbers have two seagoing vessels, a motorized boat and a 30-foot Yugoslavian sloop. The cars and boats carry them to their four homes — the main one in Wellesley, Mass., their converted riverside boathouse in Norwell, Mass., and two houses in Florida. They enjoy maintaining and refurbishing houses, vehicles, and vessels, doing as much of the work as possible themselves.

Weight-watching. With a nutritionist and former director of the Framingham Heart Study in residence, eating in the Dawber household reflects a consciousness of weight-controlled, low-cholesterol diets. Dawber himself has to watch his weight and cholesterol, and does so pretty well, but he occasionally cheats in private, just as any other dieter does.

"Semi-retirement" from BUMC is the third phase of Dawber's career. Before the second phase, the Framingham Heart Study years, he did the 12-year stint in the clinical branch of the Public Health Service. From a residency in a large active hospital in Norfolk, Va., he transferred to the Coast Guard when World War II broke out. Before the hostilities began, he served as the medical officer aboard a patrol ship halfway across the Atlantic. When the U.S. entered the War, Dawber was transferred to the 7th Naval District in Florida as its medical officer. He was responsible for supervising the medical care of 20,000 military men in that district, plus their families.

With this varied career behind him, Dawber now hopes to retreat from the Framingham Study, MRFIT, and BUMC so he can plunge into the summary monograph under a grant from the Commonwealth Fund. He says he expects to make his professional exit upon completing the monograph, but that seems unlikely for someone as vitally concerned with coronary heart disease as he is. He'll sail his Yugoslavian boat down to Naples to retire, but no one will be surprised to find him poking into some sort of new caper.
Hall of Medicine sculpture display creates a 'spiritual hearth'

by Lorraine Loviglio

In 1940, armed with a commission from the Army Medical Museum and a determination to bring an awareness of their heritage to medical students, Doris Appel, a young sculptor and medical historian, set to work transforming 12 tons of clay into an enduring memorial to the giants in the history of healing.

She recalls that she worked in a frenzy of inspiration in the large barn-studio behind her house in Lynn, sometimes sculpting so far into the night that she fell asleep in the studio. "Bernard (her husband) would come out in the morning and find me there, and he would say, 'I'll get breakfast for the children. You just keep on with it.' "

Doris Appel kept on with it, and the result was the Hall of Medicine, a monumental work consisting of 12 massive stone sculptures depicting in bold relief leading innovators in the history of medicine, from the Egyptian Imhotep, who lived about 3000 B.C., to Marie Curie, who discovered radium in 1898.

Nine years in Washington. Visitors trooped through the studio to admire the work, and later came by the thousands.

Lorraine Loviglio is a Centerscope staff writer.
VESALIUS, 1514-1564. The father of modern anatomy. Keen, independent and defiant, this brilliant prodigy at the age of twenty-three became Professor of Anatomy at Padua. He reached the apogee of his life when he published his monumental work, De Fabrica Humani Corporis, in 1543. This stupendous work was the force that overturned Galen and introduced the modern era of scientific medicine.

PARÉ, 1510-1590. The father of modern surgery, the French barber surgeon who became the greatest army surgeon of history. He reintroduced the use of the ligature and introduced the use of artificial limbs, artificial eyes of gold and silver and artificial teeth of bone. He invented many surgical instruments, introduced massage as a therapeutic agent and devised many surgical operations on bones and joints.

HARVEY, 1578-1657. The most illustrious figure in seventeenth century medicine, he discovered the circulation of the blood and demonstrated the action of the heart as a muscular pump. This acted as an exciting factor, leading to the kinetic experimental physiology of modern times. He also laid down the foundation of modern embryology.

MORTON, 1819-1869. On October 16, 1846, at the Massachusetts General Hospital in Boston, he performed the first public demonstration of the use of ether as an anesthetic. This represents an American contribution that revolutionized surgery and obstetrics throughout the world and marked a major victory for mankind in its continuing struggle to conquer pain.

to see it at the Medical Museum of the Armed Forces Institute of Pathology in Washington, D.C. where it was on view for nine years. “I was always glad to see the others come, the families with children and so forth, but it was really the medical students I cared most about reaching,” says Appel.

She had always loved history and had become intensely interested in medical history after she married Bernard Appel, a dermatologist. She joined the American Association of the History of Medicine, and in time became friendly with an entire generation of outstanding medical historians, men like Sigerist and Castiglione. Her sculptured portraits of medical leaders were acquired by hundreds of medical institutions and museums throughout the United States and around the world. But the Hall of Medicine remained her greatest achievement.

During those months of intense creation in 1940, she had had a vision of creating what she describes as a “spiritual hearth” where medical students, especially, might be inspired by “the vastness, the grandeur and the spirit of the heritage of modern medicine.” Last May the vision became a reality, when the Bernard Appel Hall of Medicine, renamed for her husband, was installed in the lobby of the School of Medicine’s instructional building. It had been donated to the School by two of the Appels’ daughters and their husbands: Blossom A. Sanger, M.D., and George M. Sanger, M.D., of Coronado, Calif.; and Nancy Baler and G. Robert Baler, M.D., of Brockton, Mass.

Honored at dedication. On June 9, several hundred invited guests attended dedication ceremonies at BUSM for the sculpture display, followed by a reception in the sculptor’s honor. Mrs. Appel received an illuminated citation from the School of Medicine, presented by George E. Gifford, M.D., associate professor of socio-medical sciences and head of the section on the history of medicine. Also attending the dedication was her husband, Bernard Appel, M.D., a professor emeritus of dermatology at Tufts University School of Medicine and formerly on the staff of Massachusetts General Hospital (now University Hospital).

The historical figures depicted in the Hall of Medicine are Imhotep, Hippocrates, Galen, Maimonides, Vesalius, Paré, Harvey, Morton, Pasteur, Lister, Roentgen, and Marie Curie. A changing display of works related to the exhibit is located in a case near the sculptures. Attached to the display case are
PASTEUR, 1822-1895. His work in bacteriology is one of the foundations on which the entire structure of medicine rests. His studies on crystallography, fermentation, anthrax, rabies and his other notable achievements have resulted in his being called "the most perfect man to enter the kingdom of science." His philosophy: "I believe that science and beauty will triumph over ignorance and war."

LISTER, 1827-1912. This great surgeon was the first to appreciate the practical application of the bacteriologic researches of his contemporary, Pasteur, and to apply them in developing the antiseptic principle in the practice of surgery. He first used the carbolic acid spray as an antiseptic procedure for the entire operating room. Later this method was modified to become the principle of aseptic surgery.

ROENTGEN, 1845-1923. He discovered the production of mysterious rays of electrical energy that had the incredible property of passing completely through solid objects. With modesty, he called the new rays "X-rays." This phenomenon gave to medicine a means by which the inaccessible interiors of the body could be studied. It also resulted in the discovery of a new method of attacking cancer.

MARIE CURIE, 1867-1934. On July 18, 1898, a paper, "Sur une substance novelle radioactive, contenue dans le pechblende," by Marie and Pierre Curie, was presented at the Academy of Sciences in Paris. It announced the discovery of radium. Marie Curie's indefatigable pursuit of solutions to the problems of research will forever be an example for those who are confronted by apparently insurmountable obstacles.

several sets of headphones on which visitors may hear a 12-minute description, narrated by the sculptor, of the sculpted figures and their roles in the history of medicine.

A copy of the extremely rare volume De Humani Corporis Fabrica, by Andreas Vesalius, was loaned by the Boston Medical Library to the School for the dedication. Publication of this monumental work in 1543 marked the beginning of the modern science of anatomy. In addition, a facsimile copy of the Fabrica has been given to the University by Edition Medicina Rara, a rare book group, and is on permanent display at the School of Medicine.

The exhibit, at 80 East Concord St. in Boston's South End, is open to the public Monday through Friday from 10 a.m. to 5 p.m. Group tours may be arranged through the Boston University Medical Center's Office of Informational Services, telephone (617) 247-5606.
Matters of Record

Grants and Contracts

School of Graduate Dentistry

Water irrigating device on gingival health. F. Oppenheim. Duets Association. $5,886, 1/1/76.

Health professions student loan. Administration. PHS. $4,021, 7/1/75-6/30/76.


Studies on proline-rich salivary proteins. F. Oppenheim. NIH. $32,220, 5/1/76-4/30/77.

Chemistry of salivary proteins. F. Oppenheim. NIH. $25,000, 6/1/76-5/31/77.

University Hospital


Biomedical research support grant. J. Coffman. NIH. $145,830, 4/1/76-3/31/77.


Inter-hospital study of psychotherapy of schizophrenia. P. Knapp. NIH. $64,037, 6/1/76-5/31/77.


Control of sphincter strength. L. Harris. NIH. $53,405, 6/1/76-5/31/77.


Cholesterol distribution in erythrocyte membranes. Y. Lange. NIH. $31,495, 6/1/76-5/31/77.


Staffing for a comprehensive children's mental health and mental retardation program. G. Stechler. Commonwealth of Massachusetts. $195,862, 7/1/76-6/30/77.

Early intervention and stimulation for exceptional children. G. Stechler. Commonwealth of Massachusetts. $390,000, 7/1/76-6/30/77.

Institute for the Correction of Facial Deformities. G. Anastasi and D. Booth. Phillips Foundation. $70,000, 7/1/76-6/30/77.

Glucose and amino acid metabolism in skeletal muscle. N. Ruderman. NIH. $61,375, 7/1/76-6/30/77.

Quantitative histochemical and biochemical studies of human muscle. R. Feldman, F. Romanoff. Muscular Dystrophy Assoc., Inc. $46,999, 7/1/76-6/30/77.

School of Medicine

Nutrition education program. J. Vitale. Nutrition Foundation. $40,000, 1/1/76-12/31/76.

Immunobiology of viral leukemia and its treatment. M. Bennett. NIH. $34,199, 2/1/76-1/31/77.

Child-care program for children of drug-dependent women. F. Hardwick. Commonwealth of Massachusetts. $16,000, 7/1/76-6/30/76.

Synovial membrane and related connective tissues. A. Cohen. NIH. $100,018, 1/1/76-12/31/77.

Measurement of the cost of cancer. S. Friedman. Abt. $149,527, 12/1/75-9/30/76.

Bio-assay of nerve trophic substances. A. Politot. NIH. $17,750, 2/1/76-1/31/77.

Fellowship for Patricia Chappeil. G. Weitzenblum. NIH. $73,925, 2/1/76-1/31/77.

Postdoctoral fellowship award. F. Bennett. NIH. $29,059, 9/1/75-1/1/76.

New diagnostic tool in breast cancer. H. Wotiz. NIH. $26,400, 2/1/76-1/31/77.

Iodine metabolism of the thyroid gland. I. Rosenberg. NIH. $29,059, 9/1/75-8/31/76.


Age-related changes in chromatin proteins. A. O'Meara. PHS-NIH. $19,176, 2/1/76-1/31/77.


Study of senile mental deterioration in the Framingham Study. J. Alpert. PHS-NIH. $142,554, 2/15/76-2/14/77.

Oncology by antibody-toxin conjugates. F. Moolten. PHS-NIH. $48,693, 6/1/76-5/31/77.

Experimental optic neuropathies. S. Essig. PHS-NIH. $154,156, 1/1/76-12/31/76.

Trasicor study. L. Smith. CIBA-GEIGY. $32,230, 1/1/76-12/31/76.

Chronic alterations in tissue metabolisms after shock. N. Ryan. NIH. $32,916, 2/1/76-1/31/77.


Biological and physical properties of friend virus. R. Eckner. Leukemia Society. $31,000, 2/1/76-1/31/77.

Synthesis, biochemistry and biological testing of end organ specific anti-biologic agents. H. Wotiz. Northwestern University PARRF. $48,928, 1/31/76-12/31/76.

Physiological factors in oral drug therapy of addiction. R. Levine. NIH. $59,960, 1/1/76-12/31/76.

Phosphoproteins and phosphorylating enzymes in nematodes. R. Herrmann. NIH. $26,400, 2/1/76-1/31/77.

Steroid experiments in acute myocardial infarction. W. Hood. Upjohn Company. $12,000, 2/1/76-indefinite.

Cognitive deficits relative to chronic alcoholism. N. Butter. NIH. $64,112, 1/1/76-12/31/76.

Aggressive behavior, dominance rank and testosterone. R. Rose. Emory University. $27,563, 1/1/76-12/31/76.


Diet microflora and induction of colonic carcinoma. S. Broitman. NIH. $44,132, 1/1/76-12/31/76.

Postdoctoral fellowship. L. Oppenheim. NIH. $25,000, 6/1/76-5/31/77.
Autonomic nervous system function in bronchial asthma. R. Mathe. NIH. $29,717. 5/1/76-11/30/76.

Iodide and metabolic basis of visual responses. A. Gorman. PHS-NIH. $47,049. 4/1/76-3/31/77.

Genetic counseling study. N. Scotch. March of Dimes. $76,186. 4/1/76-3/31/77.

Classification systems: neurotic anxiety and depression. S. Fisher. PHS-NIMH. $18,899. 4/1/76-3/31/77.

Cardiac allografts in autologous radiation chimeras. M. Bennett. PHS-NIH. $31,447. 4/1/76-3/31/77.

Studies on z-dics from heart and skeletal muscle. W. Ullick. PHS-NIH. $43,447. 4/1/76-11/30/76.

Corticosteroids in the fetoplacental unit. S. Chatterji. PHS-NIH. $27,761. 4/1/76-3/31/77.


Biomedical support grant. J. Sandson. PHS-HEW. $261,305. 4/1/76-3/31/77.

Elastin structure, fibrogenesis and disease. J. Foster. PHS-NIH. $51,948. 5/1/76-4/30/77.

Pulmonary biochemistry and cell biology. J. Brody. PHS-NIH. $116,844. 7/1/76-6/30/77.

Health professions student loan. Administration. PHS. $21,510. 7/1/75-6/30/76.

Normal and pathological human brain function. M. Berman. NIH. $25,000. 4/1/76-3/31/77.


Early receptor potentials in single cones of the turtle retina. P. O'Bryan. NIH. $44,568. 6/1/76-5/31/77.

Respiratory disease. E. Simons. NIH. $87,720. 5/1/76-4/30/77.


Hypertension renal ischemia and effect of Mannitol. N. Levinsky. NIH. $103,958. 5/1/76-6/30/77.

Pulmonary academic award. B. Make. NIH. $60,120. 6/1/76-5/31/77.

Cyclic nucleotide system of Type II pneumocytes. R. Niles. NIH. $29,785. 6/1/76-5/31/77.

Regulation of tumor growth by transmembrane potential. A. Politoft. NIH. $44,568. 6/1/76-5/31/77.

The nature of the collagen-platelet interaction. E. Simons. NIH. $29,968. 6/1/76-3/31/77.


Faculty Actions

(effective Jan. 1, 1976, unless otherwise noted)

School of Medicine Appointments

Bernhard G. Anderson: Assistant Professor of Medicine.

John G. Bartlett: Lecturer in Medicine.

Carol W. Garvey: Instructor in Medicine.

Richard A. Giuckman: Assistant Professor of Psychiatry.

Velma O. Hoover: Assistant Professor of Psychiatry.

A. Alice Jacobs: Associate Professor of Microbiology and Assistant Research Professor of Medicine.

Bimal P. Jain: Assistant Clinical Professor of Medicine.

Paul A. Johnston: Assistant Research Professor of Medicine and Assistant Professor of Physiology.

Nicholas D. Kouretas: Research Associate in Psychiatry.

Yvonne Lange: Assistant Research Professor of Medicine.

John F. McCahan: Associate Professor of Medicine.

James A. McCarthy: Clinical Instructor in Neurology.

Donald B. McGaw: Clinical Instructor in Psychiatry.

Edward P. Monnelly: Research Associate in Medicine.

Khalid Nandy: Research Professor of Anatomy, effective Sept. 1, 1975.

Donald H. Osterberg: Assistant Professor of Neurology.

Rosalinda J. Ott: Clinical Instructor in Pediatrics.

Wladimir Pereira, Jr.: Assistant Professor of Medicine.

Susan M. Reace: Adjunct Instructor in Pediatrics.

Joseph C. Sequeira: Instructor in Radiology.
Day-to-day decisions. The role of the medical staff in influencing hospital behavior is significant. Individual physicians make the day-to-day utilization decisions that, in sum, determine hospital resource allocation. These physicians are individual, solo-practice entrepreneurs whose personal, clinical decision-making has a profound effect on the organizational goals and planning of each hospital.

In caring for individual patients, physicians and other providers have generally not been expected (and I'm glad of it when I am sick) to consider the resource limitations of institutions and society, although this, too, is changing. Further, physicians with staff privileges at several hospitals may have no particular stake in the success or failure of any one hospital. So the pursuit of the physicians' professional goals may also work to inhibit optimum interhospital behavior.

Administrators' role. Administrators share in responsibility for the perceived absence of joint system-wide planning. Cost reimbursement holds out few rewards for efficiency and, indeed, fosters duplication of resources and maximum utilization of those resources. The advent of unit-cost reimbursement ceilings has tended to build in cost-control incentives, but has also intensified pressure for increased patient volume. The administrator's first duty as agent of the board of trustees is to shepherd the internal operational affairs of his/her own hospital, and this fact often militates against initiating, or taking part in interhospital planning or shared services. The pressure of the fiscal bottom line clearly has contributed to myopia in planning. Thus, many administrators have tended to give a low priority to interhospital and system-wide planning, since these could result in institutional sacrifices.

The members of the boards of trustees, having no proprietary (personal financial) interest in their hospitals, are typically motivated by institutional, civic, and personal pride. These factors can tend to inhibit interhospital cooperation and foster institutional individualism.

Boards of trustees are sometimes reluctant to compromise their local prerogatives and independence. This is understandable. As stewards of the hospital's survival and growth, trustees have appropriately responded to the economic pressures that have inhibited interhospital cooperation. But trustees, and administrators as well, are learning to live with the reality that their hospitals are part of a larger delivery system. And there will be times when the best interests of their hospitals must yield to the needs or constraints of the total system.

Planning and 'regionalitis'. Before Public Law 93-641 created the new federally mandated health-care planning structure, there existed a health-care planning process, which continues to function, although altered substantially. It generally focused on relating to the state's certificate of need program, which is the mechanism by which the state health department reviews hospital requests for large capital expenditures or the establishment of new services. Local planning agencies reviewed proposed hospital projects and made recommendations to state-level decision makers. Despite the fact that the previous planning process was generally ignored (and shamefully so) by health-care providers and hospitals, the system achieved many worthy results.

On the other hand, the old planning process was to a degree characterized by "regionalitis"—that is, planning focused on the needs of specific, limited geographical areas. Ironically, regional bias and myopia tended to foster regional independence and to inhibit regional interhospital cooperation and planning. The new planning structure cuts across broad regions in an attempt to avoid the pitfalls of regional myopia, while at the same time meeting the health-care needs of individual areas, and of Massachusetts at large.

My next discussion of this subject will focus on the new federally mandated structure for health-care planning as viewed from the bottom up.
Alumni Profiles

MARTIN GOLDFIELD, BUSM '50

The man who found swine flu virus wonders if immediate vaccination is wise

by Janet Sherbin

The man who found the 1918 epidemic recalled. News of the discovery brought to vaccination is wise. Wonders if immediate year quickly committed themselves to financing a national move? No one yet knows, and a history of the isolation of the gesture, surely, but is mass vaccination really the wisest containing what Martin Goidfield found. A humanistic vaccination program of unprecedented scope in the hope of such as that one is that not enough people received vaccine 500,000 of them in the U.S. The tragedy of flu outbreaks such as that one is that not enough people received vaccine before contracting the illness. Alarmed federal officials this makes residents particularly susceptible to contagious dis­ of Health, Goidfield routinely surveys military bases and weaknesses. The recruit training center at Fort Dix is one of the best of Health office notified. Fort Meade authorities reported these to medical officers at Fort Dix on Jan. 23. The

Fort Dix medical officers were misled into thinking they had on their hands a localized outbreak of adenovirus. As a public-service gesture, the military base notified the local health office of the outbreak on Jan. 27. The matter came to Goldfield's attention the next day, and he called Fort Dix to investigate the matter.

In reviewing the Fort Meade testing conclusion that two men suffered from adenovirus Type 21, Goldfield had been uncomfortable about two factors: The illness at Fort Dix spread faster than was possible given adenovirus 21's inc­ubation period, and the illness was more severe than was characteristic of adenovirus 21. Goldfield said it seemed to him there were a number of features suggesting there was more likelihood that it was an influenza than an adenovirus outbreak. He decided to retest on his own, using more com­plete procedures.

"Colonel Dunn of Fort Dix," Goldfield recalls, "graciously submitted to us samples taken from ill individuals by the collection of throat washes. The first group of these was brought to us on the night of January 29. Over that weekend, we identified influenza viruses in the samples from several military personnel. However, in addition to the isolates of or­dinary A/Victoria, there were two specimens that gave peculiar results. It was these two that proved later to be a strain of influenza viruses that never before had been isolated in the course of an outbreak in man."

New subtype found. Goldfield continued working on his tests and within a week found the two specimens to be "startlingly new subtypes of the Influenza A virus." Goldfield's finding was confirmed within 48 hours by researchers from the federal Center for Disease Control (CDC) in Atlanta. Of crucial importance in the CDC confirmation, Goldfield says, was the fact that the agency is a World Health Organization reference center. "They had batteries of serum of every variety and could confirm that this was a new type of virus in man, and could identify it as being related to swine."

Additional specimens obtained from Fort Dix yielded another batch of A/Victoria and two additional isolates of the strange new virus. The CDC was not long in confirming these findings.

On Feb. 5, a 19-year-old Fort Dix recruit died. He was found to have been the fifth Fort Dix soldier infected with the new Influenza A virus.

Two labs had already confirmed the discovery of the new virus. Goldfield and Walter Dowdle of the CDC shared their information with the Walter Reed Army Hospital, which came up with a third set of identical test results. By mid­February, these three labs agreed that a new strain of flu virus had infected the five recruits in question, and that the four surviving ones had developed antibodies to it. A radical­ly new strain of influenza typically mounts a worldwide assault, since most people have no immunity to it. Influenza A/Swine, as it was called, showed signs of a potential pan­demic.

Search for a vaccine. Even before full identification of the new strain of Influenza A had been made, and before independent
confirmation of results was obtained from other labs, Goldfield had called Edwin Kilbourne at the Department of Microbiology at New York’s Mount Sinai Hospital and proposed that Kilbourne start making the genetic crossing necessary to develop a vaccine candidate for the new virus. It had taken only two weeks to isolate and identify the strange virus and to start development of a strain of the new virus suitable for vaccine production. Soon thereafter, the federal government authorized four drug companies to produce enough vaccine to immunize the entire population of the United States in the early fall.

Why prepare enough vaccine to immunize more than 200 million people against swine flu? Will millions of lives be saved because of early action? Or is this tremendous quantity of vaccine, with its costs of production and administration, plus its side effects, going to prevent us from contracting an illness that has never been seen outside Fort Dix, N.J.?” That’s right. The swine flu virus has not been seen since those anxious weeks last winter when it appeared at Fort Dix.

The Victoria strain won. “Here is a very peculiar phenomenon,” says Goldfield. “We have at Fort Dix a population of soldiers who were probably highly immunized by repeated infections with close relatives of A/Hong Kong since about 1967. And all of them had been immunized against a close relative of A/Victoria, which was A/Port Chalmers. Yet, despite the odds against the survival of A/Victoria in this population, and the soldiers’ susceptibility to the new strain of A/Swine, it was not the swine virus that prevailed. It was the Victoria. A/Swine disappeared completely after February 5 and has not been seen again in the entire world.

“By comparison, the A/Victoria continued on at Fort Dix well into April. In addition, exhaustive surveillance in New Jersey succeeded in identifying 200 cases of influenza from whom the virus was isolated. Every one of those cases was A/Victoria. Not a single A/Swine. There has been no A/Swine in the civilian population in New Jersey.”

“We don’t know what this means,” continued Goldfield. “It’s never before been observed. Never before have two radically different variants of the same type of flu existed at the same time (the A/Victoria and A/Swine variants of A/Hong Kong). It’s true that we have never before identified a radically new strain of Influenza A that didn’t ultimately emerge as a pandemic strain. It’s entirely possible that what we have observed here is the emergence of a new strain that did not have the properties adequate to permit it to survive in a human population. Or it may be the forerunner of a new strain that will sweep the world.”

But where did it go? Will it come back?

Proponents of the government’s immunization program assume a swine-flu pandemic will occur this fall or winter. They had hoped to begin immunizing the elderly and those at high risk in late August, followed by mass immunization of most of the rest of the population. Vaccination of any kind has its risks, and Goldfield objects to immunizing people against a virus that hasn’t appeared since its initial scare in January. And what do we do, he asks, if we immunize everybody in September, and the swine flu appears the following spring, after immunization has worn off and we’ve run out of vaccine?

Machinery should be ready. “I did criticize the federal program of immunization, but I was very strongly in favor of production of the vaccine,” Goldfield said. “It was I who arranged for the preparation of a vaccine candidate strain. There was unanimous agreement that the administrative machinery should be ready to administer it.

“But I thought it was unwise to prepare irrevocably to immunize an entire population,” he continued, “before knowing the frequency or severity of side effects and the efficacy of the vaccine. We know we’re not going to recommend immunization for those sensitive to eggs or feathers, or to babies and pregnant women. I recommended manufacturing the vaccine and preparing to deliver it if needed. We should do unprecedented surveillance around the world. At the first signs anywhere that this strain is alive and well, we could then make appropriate judgments. A pandemic isn’t like a bonfire that sweeps the world. There have just about always been premonitory waves.”

The more sober alternative. “In my judgment, weighing the relative risks of the two alternatives, I think the more sober alternative is to be ready to administer the vaccine.”

Goldfield’s wait-and-see attitude is not popular with government officials or scientists who fear that Influenza A/Swine lies dormant among us already. Martin Goldfield hopes his astute eye caught only a freak occurrence of an influenza virus mutation too weak to survive in human beings. But if A/Swine reappears strong and ready to attack, if one health department reports one more case of swine flu, he’ll be the first physician to load his injector gun with vaccine.

NLOGHA OKEKE, BUSM ’55

His ‘interrupted dream’ of a hospital in Nigeria may soon become a reality

by Linda Lotridge Levin

GROWING up in Nigeria, Nlogha Okeke had a dream. He almost fulfilled it once, but that fulfillment was cruelly interrupted by war. Now, if his plans go according to schedule, Okeke’s childhood dream will become a reality this fall for the second time, and for good, he hopes.

A graduate of the School of Medicine in 1955, Okeke came from a country where 50 percent of the children did not live to become adults. But he was one of the lucky ones, and he never forgot it. Someday he would be a doctor and have a hospital of his own in Nigeria. He would try to make sure that the next generation of children did live to become adults.

Linda Lotridge Levin, a former staff reporter for the Providence Journal and Evening Bulletin, is a freelance writer.
Niogha Okeke, M.D.

'A great challenge.' "Running my own hospital is a great challenge, and it is also a great responsibility. The medical needs in my country are so great. It is my duty to help my people," Dr. Okeke says.

His own father, a lumber dealer in Nnewi, a city in eastern Nigeria, had only a grammar school education. But knowledge is a prized acquisition in Nigeria, and when the time came, Okeke and his three brothers were sent to college. Okeke came to the United States, to Bates College in Maine. After he completed his education at Bates, he attended BUSM, and interned at Boston City Hospital. He completed his residency there as the chief resident in surgery in 1960.

Okeke was 34 years old, and it was time to return to Nigeria with his wife, Ifeoma, a nurse and graduate of Simmons College, in Boston. It was time to fulfill his dream.

The Nigerian government, seeking to upgrade the country's health care, gave him a bank loan and 12 acres of prime land in Enugu, near his native city. He had a promise of unlimited drugs from American pharmaceutical companies, and supplies from Europe. So he set to work building the sprawling, concrete, one-story, 100-bed Enugu Medical Center.

Full-service hospitals rare. Outpatient clinics had been in operation in Nigeria for decades, but full-service hospitals were rare. The new medical center would fill a great need: Hospital diets with their high nutritional standards would replace food provided by patients' families, pregnant women and nursing mothers would receive the needed care and nutrition, and doctors would be on call 24 hours a day.

But Okeke's medical center was in operation less than seven years when, in May, 1967, Nigeria's eastern region seceded, proclaimed itself the Republic of Biafra, and civil war broke out. The hospital was damaged by rockets, its equipment and books lost, and eventually the Biafran government took it over and turned it into a psychiatric hospital.

"I came back to Boston in 1969 with my family. I planned to spend only three months here getting drugs to send back home, but the war ended and the government refused to return the hospital to me," Okeke says.

He moved his family to New Bedford where he has practiced general surgery for the last six years.

An invitation to return. Earlier this year, a stabilized Nigerian government gave the hospital back to its board of trustees, which in turn asked Okeke to return as soon as possible and get it going again.

"It was a difficult decision to make," he says. His family had put down roots in New Bedford, and they were not enthusiastic about going back to Nigeria. But Okeke had a dream he had not forgotten. He chose to accept the challenge of the hospital trustees.

The Okekes' son and daughter remain in college in the Boston area, while the two younger children went to Nigeria with their parents. Mrs. Okeke was graduated from Suffolk University in June this year with a master's degree in business administration, and she will administer the business side of the hospital while her husband concentrates on the medical aspects.

Just before he left New Bedford in mid-June, Okeke sat in his study in the family's grey, frame, Victorian home in one of the city's upper-middle-class neighborhoods and talked about his country, his hospital and the medical problems there.

Help from New Bedford hospital. Speaking rapidly in accented English, Okeke said the hospital would need some repairs, but that St. Luke's Hospital in New Bedford had donated 20 tons of equipment.

But to ship 20 tons to Nigeria costs $30,000. "We can get all the drugs and equipment we need, but we need money to pay the shipping," he says.

Currently, Dr. Okeke and the Nigerian-American Hospital Foundation, which was set up to sponsor the hospital, are seeking doctors in pediatrics, obstetrics, surgery, ophthalmology and radiology either to live permanently in Enugu or to come there for short terms.

Since the foundation sponsors the doctor, and the hospital is a non-profit institution, the doctors' expenses will be tax-deductible. Anyone interested can write to the foundation at 10 Kearney St., Needham, Mass., 02194.

Competing priorities. Okeke says that the effort to overcome health problems today in Nigeria must compete with other postwar reconstruction priorities like road and bridge building, housing and industry rehabilitation, and the upgrading of education.

Most Nigerians, he says, still live in villages, and although many of these communities boast modern amenities, the people still must be taught to read and to eat proper foods.

Beginning this September, every child of school age will be able to get a free education, and in a few years, it is hoped that 50 percent of the people in Nigeria will be able to read.

Two of the major medical problems Okeke and his staff face are parasitic infections, common to equatorial countries, and malnutrition. Inflation is up 200 percent, he says, and it is impossible for the families in villages to buy meat, a major source of protein.

"Before the war, we had one nurse just teaching mothers the proper way to feed their children. We wanted pregnant women to have prenatal care, but many were reluctant. After the first set of deliveries, though, they saw the difference in the mothers and the babies and were not so hesitant."

In 1966, a year before the civil war began, the hospital treated 2,245 in-patients and 42,446 out-patients. Okeke likes to point out that his hospital had a ratio of one doctor to 17 beds, which he calls "a great achievement in Africa."

Okeke said his hospital, which should be open by this fall, will be self-supporting within two or three years. He adds that compared to the cost of opening a 100-bed hospital in the United States, the money needed to get the Enugu Medical Center back on its feet is minimal—about the same as it would cost to equip three private rooms in this country.

When he returned to Nigeria after college, Okeke dreamed of having his own hospital, seeing the country's medical standards improve, and training younger doctors to take over while he retired and wrote about his work. He hopes that maybe this time, he will not be interrupted.
Alumni News

Anthony V. Porcelli, '55, and Mrs. Porcelli, traveled to Boston from Montvale, N.J., to attend the May dinner of the Dean's Club.

BUSM Alumni Association succeeds in $105,838 fund-raising campaign

A total of $105,838 was raised in the Alumni Association 1975-76 Annual Fund drive, which ended June 30, the first time in BUSM history that alumni giving topped the $100,000 mark. Last year the fund raised $62,000.

The record figure represents the gifts of more than 850 alumni, or better than 31 percent of the 2,700 persons solicited, according to the Alumni Office. It includes gifts of $1,000 or more by 50 Dean's Club members and contributions of $100 or more by more than 400 Century Club members.

Membership in the Dean's Club rose from only eight persons last year, and Century Club membership increased from 296 last year.

The largest single beneficiary of the fund will be the Student Revolving Loan Fund, with the remainder going for library support, student grants, student activities and other needs of the School, as determined by the Alumni Association, which reviews all requests for monies from the fund.

Bernard Tolnick, M.D., '43-A, served as chairman of the Annual Fund Campaign Committee, and Barry M. Manuel, M.D., '58, was chairman of the Dean's Club Membership Committee. The campaign was also boosted by the efforts of Class Reunion Chairman Martin B. Levene, M.D., '50, and Herbert Mescon, M.D., '42, then president of the Association.
More than 400 alumni join 1975-76 Century Club

Listed below are the more than 400 alumni who have enrolled in the 1975-76 Century Club. Membership in the Century Club is open to all alumni who contribute $100 or more during a fiscal year to the Alumni Association’s Annual Fund.

CENTURY CLUB
Anonymous
George H. Abbot ’60
Crawford W. Adams ’42
Dwight M. Akers ’53
Stephen J. Alphas ’55
Edward P. Andersen ’64
Carol E. Anderson ’72
Donald L. Anderson ’40
Dorothy S. Anderson ’40
Fred A. Anderson ’40
Neil E. Anderson ’48
Ruth M. Anderson ’40
E. D. Angulo ’52
Philip J. Arena ’61
Jacob J. Arendt ’32
Gordon D. Arnold ’43-B
Guy B. Attona ’33
Thomas C. Bagnoi ’64
David A. Bailen ’67
Arnold Bajek ’53
G. Robert Baler ’50
Betty J. Bankforth ’47
Bryan Barber ’62
Donald Barkan ’45
Gerard A. Barnaby ’45
Howard C. Beane ’57
John Belsky ’34
Leonard W. Benedetto ’31
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Fred W. Benton ’45
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S. Arthur Boruchoff ’51
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Thomas F. Boyd ’48
Robert D. Boynton ’45
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Matthew D. Branche ’53
James T. Brooks ’29
Fairy P. Brown ’21
Ralph O. Brown ’50
William Farrar Brown ’47
Willard E. Buckley ’33
Robert S. Burroughs ’64
Leonard B. Bushnell ’62
Alexander S. Butkiewicz ’60
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George E. Casaubon ’43-B
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Marion Macdonald Castagno ’43-A
Joseph R. Cataldo ’58
William J. Cates ’58
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Adolph B. Ciachko ’51
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Charles T. Cloutier ’65
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Samuel Clive Cohen ’35
Roger M. Cole ’47
Gerald M. Collins ’41
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Robert L. Conrad ’60
Mark H. Cooley ’60
Menahem Cooperstein ’41
Norman D. Corwin ’57
Charles C. Thompson '42
Toshihisa Takei '62
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Charles C. Thompson '42
Douglas S. Thompson '51
Leonard B. Thompson '31
Theodore A. Tromovitch '57
Guy N. Turcotte '51
Ellsworth A. Twible '47
Joseph P. Van Der Meulen '54
Salvatore Vassale '42
Francis E. Wanat '63
George C. Wang '56
Donald O. Ward '47
Arthur B. Wein '39
George C. Wang '56
Edward D. Swiss '55
Joseph P. Van Der Meulen '54
Leonard B. Thompson '31
Douglass S. Thompson '51
Charles W. Woodcock
Douglas N. MacInnis
Edmund L. Saunders
Anthony R. Gabriel
Robert L. Miller
Russell G. Sandberg
Charles W. Woodcock
Douglas N. MacInnis
Edward D. Swiss '55

Listed below are those alumni who made contributions to the 1975 Annual Fund between Jan. 1, 1975 and June 30, 1975.

### Contributors through AMA-ERF

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<thead>
<tr>
<th>Year</th>
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<tr>
<td>1915</td>
<td>Henry F. Dauphin</td>
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<td>Miriam G. Katzeff</td>
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<td>Arthur P. Fisch</td>
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<td>David A. Fleishman</td>
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<td>Ronald A. Grant</td>
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<td>1941</td>
<td>J. Kent Hewitt</td>
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<td>1942</td>
<td>Jean G. Janelle</td>
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<td>Stephen L. Laflin</td>
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<td>1943</td>
<td>Burton D. Tepler</td>
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<td>1943</td>
<td>Barbara J. Rose Baum</td>
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<td>1945</td>
<td>Henry S. Eden</td>
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<td>1946</td>
<td>Carl J. Brotman</td>
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<td>Mark H. Allen</td>
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<td>1948</td>
<td>Albert L. Langan</td>
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<td>1949</td>
<td>Elisabeth B. Simms</td>
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<td>1950</td>
<td>Marvin D. Berman</td>
</tr>
<tr>
<td>1951</td>
<td>Stephen F. Osborn</td>
</tr>
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*Non-alumni contributors*

Marcia and Simon Berman
John T. Bowers, Jr.
Edward's Office Supplies
Employers Insurance of Wausau
Robert and Nancy Levy
George I. Lewis
Eva D. Mabee
Mr. and Mrs. Joel Wolfin

*Matching contributors*

American Telephone and Telegraph Co.
The Gillette Company Safety Razor Division
Southern New England Telephone Insurance Program — Class of 1953
H. Jerome Crampton
Carl G. Freese
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John P. Holbrook
Alfreds Krisiukenas
Thomas Leavitt, Jr.
Ernest W. Lowe
Helen A. Papaioanou
Felix P. Rosenhain
Michael P. Tristan

*In Memoriam*
Dean John I. Sandson chats with Peter F. Jeffries, '60, and Jean F. Arnold, '61, of Peterborough, N.H., at the Dean's Club Dinner at the Ritz Carlton Hotel. Jeffries and Arnold sponsor an annual scholarship to a third- or fourth-year student interested in a rural practice.

Alumni contributors to the 1975-76 Annual Fund

1909
George E. Boynton
1914
Edwin D. Lee
1916
Alma Binasco LeCerci
1917
Samuel L. Marnoy
1918
Anthony Macaluso
1919
Clifton B. Leech
1921
Fairy P. Brown
Wallace F. Hamilton
Marjorie M. Smarzo
1922
Marion Dallas-Mastroianni
Jacob M. Masters
Janaro Suarez
1924
Louis Caplan
Pedro O. Martinez
Herman Sellinsky
Franklin L. Wilbur

1925
Harris E. Bowmar
Rachel Hardwick Burgess
Nicholas J. Capece
Sarah Fong-Sung
*George Levene
Wayne D. Stettler
Marion A. D. Wilkinson
1926
Jose Chavez-Estrada
Norman W. Elton
Robert O. Gilmore
Cyril Israel
Gary J. Kapoloulos
James M. Marlin
Louis R. Paul

1927
Enso K. F. Ronka
Ladislava B. Stya
Irving H. Uvtisky
Grace Blauvelt Welles

1928
Kenneth Christophe
Otto L. Churney
Carl A. DeSimone

1929
A. Henry Fox
Morris Katcher
Samuel Segal
Irving Swartz
James T. Brosnan
Muriel Case-Downer
Max Faber
Angelo L. Gentile
Valerian S. Michalowski
End K. Rutledge
Albert V. Saradarian
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1930
H. Archer Berman
Herbert K. Bloom
Harold Burger
Nathan L. Fineberg
Alphonse L. Forzati
Leslie S. Harrison
Laura G. Jacques
Nathan Krinsky
Edward W. H. Lagerstedt
Grace R. Martus
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1931
Leonard W. Benedetto
H. Arthur Benson
Matthew N. DePasquale
Joseph Factor
George Ferre
Anthony A. Iavazzo
Ellis I. Lewis
Nicholas Padis
Norris H. Robertson
Leonard B. Thompson

1932
Jacob J. Arentsram
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Bessie F. Brown
Robert J. Donovan
Joseph Hammer
J. Mark Hiablert
Philip E. Sartwell
Charles E. Towne
Carl E. Trepp
Eva S. Vandez

1933
Guy B. Attona
Willard E. Buckley
John F. Connell
Frank P. deLuca
Philip P. Denning
Leonard J. Flanagan
Dorothy Prior Hiebert
Michael J. Kannan
Herbert H. Smith
Monica Harnden Snyder

1934
John Belisky
Francis X. Foley
George R. Gagliardi
Francis C. Kennedy
Henry H. Lerner
Jerome A. L'Heureux
Charles J. Monestere
John J. O'Brien
Joseph E. Porter
Hilda Ratner
Charles Schlosberg
Edwin Y. Stanton
Burnham S. Walker
Philip E. Zanfagna

1935
Louis J. Aiello
Constance G. H. Cincotti
Samuel Olve Cohen
George M. Connor
Jacob Federman
Mark Giftords
Burton C. Grodberg
Israel M. Kamens
Henry H. Lerner
Jerome A. L'Heureux
Charles J. Monestere
John J. O'Brien
Joseph E. Porter
Hilda Ratner
Charles Schlosberg
Edwin Y. Stanton
Burnham S. Walker
Philip E. Zanfagna

1936
Morris Fogel
Nathan G. Gordon

1937
Morris Coshak
William F. Crosby
Oscar Z. Daashe
Maurice E. Green
James Harrison
Pauline Luzakas
Harry R. Mushlin
Sidney Olans
Anthony R. Palma
Samuel E. Paul
Michael M. Ross

1938
George D. Bissell, Jr.
Harold F. Chase
Louis B. Crowell
Robert A. Frost
Herbert B. Gyer
Roy W. Nelson
Theodore A. Potter
Bertha P. Rodgers
Irving Silverman

1939
James G. Boyd
Sidney Cohn
Timothy L. Curran
Saul K. Copen
Harold Marcus
John M. McVey
Maurice R. Ruben
Richard C. Taylor
Arthur B. Wein
Frank J. Zsidos

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Donald L. Anderson
Dorothy S. Anderson
Fred A. Anderson
Ruth M. Anderson
William Berenberg
Abraham I. Binder
Robert E. Block
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William H. Horton
Herbert M. Levenson
Julius Litter
Samuel R. Manes
Bernard F. Mann, Jr.
Isabel S. Money
Joseph F. Palmieri
Ivan S. Ralston
Pauline G. Spear

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Franklyn D. Berry
Elsa Chaffee Bodon
Gerald M. Collins
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Joseph H. Kulch
Francesca M. RacioppI
Melvin D. Roseman
Sydney Grace
Peter P. Gudas
John F. McManus
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The 1977 annual meeting and banquet of the BUSM Alumni Association will be held on Saturday, May 14, 1977, at the Copley Plaza Hotel. Alumni are asked to mark their calendars now and plan to be on hand for that occasion.
Class Notes
School of Medicine

1919
CLIFTON B. LEECH is director emeritus of the Coronary Care Unit at Holy Cross Hospital in Fort Lauderdale, Fla. He is on the active staff and in the EKG department and has a private practice.

1925
T. VINCENT CORSINI of Quincy, Mass., was among 48 physicians honored in May, 1976, by the Massachusetts Medical Society in recognition of 50 years of membership in the society. The honored physicians were presented with gold badges at the annual meeting of the council at 57 Park Plaza, Boston.

A. DANIEL RUBENSTEIN and his work in the field of public health in Massachusetts were the subject of "Who's Who in MMS" in the April, 1976, issue of the Massachusetts Physician. In addition to teaching epidemiology at the School of Public Health and later at MIT, Rubenstein served as director of hospital facilities and deputy commissioner for the Massachusetts Department of Public Health until his retirement in 1969. He has worked since then as a hospital consultant and administrator at Mount Pleasant Hospital in Lynn, Mass.

1933
PETER P. GUDAS of Needham, Mass., writes that classmate LOU RAVREBY is recovering from cardiac surgery and has retired as senior physician at Norfolk County Hospital in Braintree, Mass.

1944
LEONA NORMAN ZARSKY writes from Brockline, Mass., that her daughter Barbara, Yale '73, graduated from the University of Pennsylvania Law School in June, 1976.

1948
HELEN O'BRIEN-CULLINA writes, "I am still pediatrician for the Child Health Clinic of the Hartford (Conn.) Health Department with a hobby of supporting colleges! We have three children, David and Carol, and Notre Dame this year, and two more in high school."

1950
NADYA KONIKOV BLEISCH writes from St. Louis, Mo., "My son, Bill, graduated from Harvard, magna cum laude, in June. He has been appointed to a fellowship at Rockefeller University in New York. His field is microbiology. Barbara is a sophomore at Yale. Pam is in her second year of high school. Virgil and I are still in practice in pathology."

1951
BURTON I. KORETZ has been elected executive vice-chairman of the National Scientific Advisory Committee of the National Foundation for Ileitis and Colitis in New York City.

1952

ALAN D. WEINER was appointed chief of orthopedic surgery at Brockton Hospital, Brockton, Mass., in November, 1975.

1953
JOHN T. KAEMMERLING is now chief, Pulmonary Disease Section, and assistant chief of medicine at the Veterans Administration Hospital in Providence, R.I. He is also associate professor of medicine at Brown University.

PAUL M. LERNER writes from Asheville, N.C., "Have a five-man urologic group. Love living in the land of the sky. Have three very bright and very good-looking kids. Current wife is same as original wife. Look forward to our 25th medical reunion, where I know everyone will have aged but me."

WILLIAM L. McCARTHY of Hingham, Mass., writes, "My daughter Sara, Yale '76, is going to UCLA for her Ph.D. (hopefully) in developmental psychology. My son, David, is Yale '80, and my daughter Carol will graduate next year from Boston College School of Nursing. Meanwhile, Janet and I have been married 25 years as of June."

JOSEPH P. VAN DER MEULEN of Rolling Hills Estates, Calif., is professor and chairman of the Department of Neurology at the University of Southern California. The 1976 graduating class of USC School of Medicine selected him to receive the Kaiser-Permanente award for excellence in teaching.

1955
JOSEPH T. MULLEN will retire from the U.S. Navy on Sept. 30 after 20 years of service. He will continue in his association with Eastern Virginia Medical School as professor of surgery and, with that title, will be director of surgery at DePaul Hospital in Norfolk, Va.

1957
RALPH A. GODDARD writes from Woodland Hills, Calif., "My wife, my five children and I send 'cheers' from California. I have a busy practice of child, adolescent and adult psychiatry. It is emotionally very rewarding work. I am board certified in both adult psychiatry and child psychiatry and do mostly private practice in the San Fernando Valley (N.W. Los Angeles). I am also medical director of the psychiatric clinic of the Crippled Children's Society, and consultant to numerous hospitals, schools and institutions. In addition, I give lectures at local colleges as an instructor at UCLA Medical Center. I shall forever be grateful to those at BUSM who allowed me the opportunity to pursue the study of medicine, despite my paralysis from polio and my limitation to a wheelchair."

DOROTHY PITULA-GROCKET assumed the position of teaching head, Department of Pediatrics, University of Saskatchewan (Regina Campus) in January, 1976.

JOEL RANKIN has been appointed full-time chief of the Department of Obstetrics and Gynecology at Framingham Union Hospital, Framingham, Mass. A member of the consulting staff at Framingham Union for some time, he had been serving as assistant director of Ob-Gyn at Boston City Hospital.

1958
JOSEPH R. CATALDO writes, "Full retirement from military in grade of colonel. Now integrating specialty of preventive medicine with a very active practice of family medicine. The Green Beret and parachute days are over, and I try to fit the mold of a peaceful family doctor. And loving this second career! Living with wife and son in Alexandria, Va."

RALPH D. POWELL, JR., has been serving as associate professor of pathology at the University of Kentucky in Lexington, since February, 1976.

LOUIS W. SULLIVAN has been appointed clinical professor of medicine (hematology) at the Emory University School of Medicine in Atlanta, Ga.

JEROME D. WAYE is currently in the private practice of gastroenterology in New York City, and is chief of the Gastrointestinal Endoscopy Unit at Mount Sinai Hospital, New York.

1959
JOHN M. BENNETT of Rochester, N.Y., was recently promoted to professor of oncology in medicine at the University of Rochester School of Medicine and Dentistry. He is also continuing as director of medical oncology at Strong Memorial Hospital and is associate director for clinical oncology at the University of Rochester Cancer Center.

FRANCIS COMUNALE, director of anesthesiology and respiratory care at Cambridge Hospital, Cambridge, Mass., has been appointed acting director of health and hospitals for the City of Cambridge. He is currently chairman of the review committee of the Bay State Health Care Foundation, assistant clinical professor of anesthesia at Harvard Medical School, and clinical instructor in anesthesiology at BU.

GERALD ROSENBLATT is a physician-in-chief of Quincy City Hospital, Quincy, Mass. He is also coordinator of BUSM student teaching at that hospital.

1960
CHARLES F. EADES writes from Newville, Mass., "Have recently given up private practice to join the MIT medical department to head up their ob-gyn division. Enjoying it!"

PHOEBE KREY LANZONI has joined the New Jersey Medical School of the College of Medicine and Dentistry of New Jersey in Newark as assistant professor of medicine and director of the division of rheumatology.

ELEANOR MCQUELLON of Waverly, N.Y., was certified this year in forensic pathology. She is also certified in anatomic and clinical pathology.

1962
ROBERTA APFEL SAVITZ of Auburndale, Mass., has completed a psychiatry residency and is now working at Beth Israel Hospital and Harvard Medical
School, both in Boston. She also has a
part-time practice.

1963

MICHAEL A. DIAMOND writes from Livingston, N.J. "I am in practice in allergy—have medicine boards, and got allergy and chest boards in seven-month period. I have some contact with LOU LEVOVSKY, '63, doing allergy and internal medicine in Fall River, Mass."

MICHAEL G. HIRSH has been appointed associate chief of pediatric at Genesee Hospital in Rochester, N.Y. He is also a clinical instructor of pediatrics at the University of Rochester School of Medicine and Dentistry, and assistant pediatrician at Strong Memorial Hospital. He is a fellow of the American Board of Pediatrics.

1964

JAMES W. SHEPARD writes from Natick, Mass., "Joined by BUD GRENZENBERG, '64, in practice of otolaryngology." DUANE L. SMITH writes, "We moved from Tanzania to Kathmandu, Nepal, in the fall of 1975. I am now working for Management Sciences for Health in Cambridge, Mass., as chief of party for an assistance project to the Ministry of Health of Nepal, where we will be living for the next three years. The project is concerned with development and expansion of a paramedical worker-based rural health service to provide minimal medical services to most of Nepal's 12 million rural poor by 1980."

1965

ALAIN DE LA CHAPELLE is now in the private practice of psychiatry in New York City.

1966

RICHARD D. BLAND, researcher in the Cardiovascular Research Institute and assistant professor of pediatrics at the University of California in San Francisco, has been doing research with two colleagues on how furosemide, a potent diuretic, reduces fluid movement into the lungs of premature newborns and young infants. The researchers report that increased urination caused by the diuretic reduces the amount of fluid that moves out of blood vessels of the lungs and into lung tissue. Dr. Bland presented the team's findings at the American Federation for Clinical Research annual meetings in Atlantic City, N.J., on May 2, 1976.

1968

HAROLD M. GINZBURG has had several careers since he left BUSM, including a two-and-a-half year stint with the U.S. Navy, riding nuclear submarines and supervising deep-sea diving activities. About 18 months ago, he completed his residency in psychiatry and is now the chief of evaluations for the National Institute on Drug Abuse in Rockville, Md.

1969

BRUCE L. EAMES writes from Woodbridge, Va., "Out of Navy—going into practice in ENT in Rome, N.Y."

1972

THOMAS W. FEELEY has completed his residency in anesthesiology at Harvard's Beth Israel Hospital, Boston, where he was chief resident. Since July 1, he has been assistant professor at the University of California, San Francisco, and the co-director of the intensive-care unit of San Francisco's Moffit Hospital. His son, Brian, was two years old in July.

ALLEN E. OTT has just finished his residency in otolaryngology at the University of Pennsylvania and will be on the staff of Mather Air Force Base Hospital in Sacramento, Calif., for the next two years. He recently received an award for outstanding performance as a resident in obstetrics and gynecology.

STEPHEN R. SMITH has been appointed an assistant professor of family practice at the University of Connecticut Health Center in Farmington. Dr. Smith, who assumed the post in February, supervises residents in family medicine, teaches medical students at UConn Medical School, and conducts research in family medicine and primary care. Prior to this appointment, he was associated with Dr. Morris Sulman, worked at the Multi-Service Center in New London, Conn., and was a consultant for the Connecticut State Social Services Department.

1973

EVAN E. MORTIMER of Tacoma, Wash., was married on May 10, 1975, to Rosemary E. Sullivan, BU School of Nursing, now a nursing instructor at Tacoma Community College. STEPHEN T. OLIN recently completed a three-year residency in family medicine at Lancaster General Hospital in Lancaster, Pa. During his third year there, he received the Mead Johnson grant, a cash award given to 18 residents across the country. Dr. Olin will pursue a postdoctoral fellowship as a Robert Wood Johnson Clinical Scholar at the University of Pennsylvania and will complete a portion of the research required by the fellowship at the Lancaster General Hospital during the next two years.

1974

ARNOLD BERMAN is now chief resident in family practice at Middlesex Memorial Hospital in Middletown, Conn. His wife gave birth to their first child, Linda Jill, on May 13, 1976.

1975

HOMER W. RYAN and his wife, Dr. Rebecca Ryan, have been sworn in as lieutenants in the U.S. Navy's Medical Corps Reserve. They are undergoing training in Detroit, Mich.—he, at St. John's Hospital, and she, at Henry Ford Hospital.

School of Graduate Dentistry

1961 Oral Pathology

SEYMOUR HOFFMAN, who has been residing in Rockville, Md., retired from the Navy in June and is joining the faculty at the University of Alabama in Birmingham as professor of pathology.

1962 Periodontics

ALLEN WAINBERG is an examiner in periodontics at the Royal College of Dentistry in Canada in Montreal, Quebec.

1965 Periodontics

ROBERT I. KELFER has been appointed assistant clinical professor of periodontology at Tufts University School of Dental Medicine.

1966 Oral Surgery

JEROME BECKER of Toronto, Ontario, currently serves as president of the Ontario Society of Oral Surgeons, governor of the board of the Ontario Dental Association, and head of the oral surgery section at the Hospital for Sick Children in Toronto.

1968 Orthodontics

LEWIS KLAPPER, who also earned a D.Sc. degree in oral biology from the School of Graduate Dentistry in 1975, has been appointed an assistant professor of orthodontics at the Loyola University School of Dentistry in Maywood, Ill. In July, he was promoted to assistant department chairman.

1969 Oral Surgery

MEHDI BALAKHANI received an M.D. from Hahnemann Medical College and Hospital of Philadelphia. He will complete a surgical residency at Wilmington Medical Center, Wilmington, Del.

1970 Orthodontics

WILLIAM R. KOPLIN of Franklin, Mass., has just completed a one-year term as president of the Franklin Jaycees. He has been appointed to the board of directors of the Franklin Rotary Club.

1975 Pedodontics

RICHARD P. MUNGO writes, "I am now enjoying a craniofacial anomalies fellowship in cleft palate therapy at Rancho Los Amigos Hospital in Los Angeles, Calif., rotating through all specialties involved: plastic surgery, ENT, prosthodontics, orthodontics, pedodontics, speech pathology and pediatrics."

Necrology

School of Medicine

David P. Hayes, '03
Varazdat H. Kazanjian, '14
Roger M. Burgoyne, '22
James A. Ramsay, '24
Glicerio D. SyBico, '24
Henry Matez, '24
George Levene, '25
Madeline Fieke, '27
Salvatore Liotta, '27
Charles E. White, '29
Veri J. Throckmorton, '33
Robert W. Nespor, '33
Joseph R. Provenzano, '35
Paul H. Sullivan, '37
Mabel Wood Weaver Mousselet, '40
Arthur S. Ninomiya, '44
Arthur M. Parker, '44
Joelle C. Hibbert, '49
Davis S. Hastings, '53
Milton D. Howard, '53

39


**In Print**

Richard H. Egdahl, M.D., Ph.D., director of the Medical Center, and Paul M. Gertman, M.D., chief of the Health Care Research Section, BUSM Division of Medicine, editors. _Quality Assurance in Health Care_. Aspen Systems Corp., 1976. 355 pp. $20. A collection of essays on current quality-assurance problems and policy options by leading authorities, originally prepared as background papers for the conference on Quality Assurance in Hospitals held in Boston in November, 1975, under the auspices of the Boston University Health Policy Center. Topics include current quality-assurance mechanisms; coordination of federal, state and private roles in inpatient quality-assurance activities; management of quality-assessment data and the question of public access; professional licensure and hospital delineation of clinical privileges; and financing mechanisms and costs in quality-assurance activities.

Thomas W. Feeley, M.D., Class of '72, (and John Hedley-Whyte, M.D., George E. Burgess, M.D., and Malcolm G. Miller, M.D.) _Applied Physiology of Respiratory Care_. Little, Brown, and Co., 1976. 552 pp. $22.50. "A comprehensive review of recent advances in the physiology and management of respiratory failure, containing over 2000 references." Feeley left Boston in July to become codirector of the intensive care unit of San Francisco's Moffit Hospital and assistant director of respiratory therapy. He is an assistant professor at the University of California, San Francisco.

William A. Anthony, Ph.D., associate professor and director of clinical training in the Department of Rehabilitation Counselling, Sargent College of Allied Health Professions (and Robert R. Carkhuff, Ph.D.) _The Art of Health Care_. Human Resource Development Press, 1976. 104 pp. $4.95 (paper). Seeking to restore the human dimension to health care in an age of advancing medical technology, the authors present a step-by-step program designed to teach human relations skills to health care professionals.


_Centerscope_ would like to know about all recently published or soon-to-be-published books and monographs (and articles of unusual interest) by Medical Center staff, faculty or alumni. Please call Lorraine Loviglio at the Office of Informational Services, (617) 247-5606.

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**Letters**

**Thoughts on 'image' spurred by article on marriage**

To the Editor:

I have sent the following letter to Norman Paul, M.D., the moderator of your magazine's panel on marriage and the physician:

Dear Dr. Paul:

As a "ghost" writer, always in search of material making up the structure of a play or novel, I digested your discussion "Marriage and the Physician" (Spring, 1976) with a great deal of interest. . . .

Possibly you might conduct another discussion on why the average second marriage is usually successful. . . . Probably the major cause of marital distress in the rat race, professional as well as business, is _loss of image_ somewhere along the line, with both partners working. [I] cured many ulcers without benefit of surgery by advising and insisting that when the husband (still biologically the head of any family) comes home from the emotionally devastating marketplace (or clinic or office) he be left alone for at least a half hour to reflect on the day's battle; [only] then [should the wife] bring up why he should whale the tar out of Jimmy for breaking the window or [the fact] that [she was] shortchanged at the local market.

It is this sort of article that makes _Centerscope_ a welcome alumni magazine.

N. Gillmor Long, M.D., BUSM '31
Wellesley, Mass. 02181

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**Medical Quarterly volumes sought**

To the Editor:

I would like to call your readers' attention to a request received by the Alumni Medical Library for a complete set of the _Boston Medical Quarterly_, published by the School of Medicine from March, 1950, through September, 1966. Anyone wishing to discuss sale of a complete set (Volumes 1 through 17) by an outside agent can contact me at 80 East Concord St., Boston, MA 02118, telephone (617) 247-6187. I emphasize that the agent is seeking complete sets only.

Irene Christopher, Librarian
Boston University Medical Center

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1 Review Course in Hematology/Sept. 30-Oct. 1, 1976/Howard Johnson’s 57 Hotel, Boston/14 hrs.

2 Recognition and Management of Medical Emergencies/Oct. 20-21, 1976/Holiday Inn, Government Center, Boston/14 hrs.


4 Pediatric Radiology in the General Hospital/Nov. 4-6, 1976/Colonnade Hotel, Boston/17 hrs.

5 Rheumatic Disease: Current Concepts and Practical Application/Nov. 17, 1976/Howard Johnson’s 57 Hotel, Boston/7 hrs.

6 Advanced Course in Colposcopy, Cervical Neoplasia and Laser Beam Therapy/Nov. 18-20, 1976/Howard Johnson’s 57 Hotel and University Hospital, Boston/17 hrs.

7 Dementia in the Aged/Dec. 1-2, 1976/Colonnade Hotel, Boston/12 hrs.

8 Medicine for Dentists Series: Drugs/Dec. 8, 1976/Boston University Medical Center, Boston/7 hrs.

9 Learning Disabilities/Dec. 11, 1976/Howard Johnson’s 57 Hotel, Boston/7 hrs.

10 Review Course in Internal Medicine/Jan. 11-June 21, 1977 (Tuesdays, 7-9 p.m.)/Boston University School of Medicine/46 hrs.


13 Corneal Disorders: Clinical Diagnosis and Management/Feb. 10-15, 1977/Cartagena, Colombia, SA./18 hrs.

14 Sexually Acquired Diseases and Dysfunction: Diagnosis and Management/April 13, 1977/Copley Plaza Hotel, Boston/7 hrs.

15 Current Concepts and Management of Diseases of the Kidney/Copley Plaza Hotel, Boston/7 hrs.


Other Programs Scheduled for Spring 1977

A Review Course in Clinical Electroencephalography/ /13 hrs.

B Advances in Clinical Neurology /7 hrs.

C Epilepsy Seminar /13 hrs.

D Microsurgery of the Larynx /13 hrs.


F Recent Advances in Pulmonary Disease /7 hrs.

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For further information please contact: Donna Marcy, Department of Continuing Medical Education, Boston University School of Medicine, 80 E. Concord Street, Boston, MA 02118. Phone: (617) 247-1973 or 247-5602.

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Detach and mail to: Ms. Donna Marcy Boston University School of Medicine Department of Continuing Medical Education 80 E. Concord Street Boston, MA 02118