1968

Boston University Medical Center

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Boston University
"I discovered that I didn't know anything about the community"

"the very fine working relationship between house officers and staff people"

"not an ivory tower type of institution"

"this is the beautiful possibility for BU"

"someone has to take care of them"

"a pretty good model of a university medical center"

"I think the patients do come first"

"1400 applications for 66 positions"

"dedicated to community dentistry"

"a partner with communities in the evolution of health care systems"

"the image of a liberal institution"
We are trying something different this year with the Boston University Medical Center's 1968/1969 Annual Report. We have let a random group of people, actively involved with the Center, express their own thoughts about what the Center means to them. To obtain these opinions, each person recorded in this report was interviewed by means of a tape-recorder. None of the actual responses has been edited, although certain portions of each transcript have been omitted in order to keep the format as concise as possible. We have copies of each complete transcript and will be happy to let anyone interested in reading them do so by contacting the Medical Center . . . 262-4200 Ext. 6141.

We hope that you enjoy this report — *Voices of the Medical Center*. If you desire additional copies please contact us at the above number or write to the Office of the Director, Boston University Medical Center, 80 East Concord Street, Boston, Massachusetts 02118.
Q. Dr. French, you're a new arrival here at the Medical Center, with considerable experience with less affluent members of our society. Do you see the Medical Center's role as that of heavy involvement with our immediate neighbors?

A. I believe that this Medical Center is like any other institution in our society today: if it wants to remain an active part of society, it's going to have to respond to what society demands as it progresses... and there is no doubt in my mind that a new day is coming about which involves segments of the community which have never traditionally been heavily involved. I really don't think we have much of a choice, but it is not going to be easily done, and everybody is not seeing it the same way that I'm seeing it... and there will be opposition to this. There is opposition within this Medical Center to this concept. Some of this opposition is active, aggressive opposition; some of it is passive opposition, but it's there nevertheless.

Q. Will our efforts in the Roxbury area and in the South End be the main thrust of your Department of Community Medicine, or will your programs reach out to other communities such as Brockton and Malden?

A. Well, I think it would be a mistake to make this a department of indigent medicine because I don't think that is what community medicine means. Certainly the community as a whole involves all aspects of society, and it would be a great mistake for us to be concerned about designing medical care just for the indigent, the black, Puerto Ricans, Italians, or just for anybody in particular. I think that the goal of a Department of Community Medicine should be to help bring about the creation of a quality of medical care which will be one quality of care to be delivered to everybody in society, regardless of their community. That's what I'm interested in. So we're interested in studying other communities.

We've been working quite a bit recently in developing a relationship to or commitment to southeastern Massachusetts, along with Dr. Egdahl, who is heavily involved in this area. On the other hand, I would hate to see us get too heavily committed to, say, southeastern Massachusetts that it could be sort of a narcotic to take our minds off the South End and Roxbury... and I think this is something that has to be guarded against.

Q. Do you see changing patterns in medical education to allow for a new emphasis on community medicine?

A. I think that we're rapidly approaching the stage in terms of medical education where all medical schools can no longer be identical. With the whole spectrum of how activity in terms of medicine, biomedical research, health care, and
delivery system research, I don’t think that one medical school is capable any longer of doing the whole spectrum any more than the old family doctor is capable of handling all the medical care needs of anybody in his community . . . he’s outlived his existence too. So this has got to happen . . . schools will become known for their major emphasis in one particular direction . . . this is the beautiful possibility for BU at the present time. I think we have a marvelous opportunity through this Department of Community Medicine . . . by tackling problems such as in the South End through our Home Medical Service and through the Roxbury Neighborhood Health Center, and through our involvement in things like Region 7, and in other areas of the country in terms of consultation and the planning and evaluation. We have a marvelous opportunity here to develop a kind of know-how and expertise to put us on the map as being known for this kind of thing. I think we’re seeing the beginning of this kind of specialization

Bernard Bandler, M.D.
Professor and Chairman, Division of Psychiatry,
Boston University School of Medicine
Psychiatrist-in-Chief, University Hospital

Q. The Medical Center’s orientation has been shifting in recent years to a much greater emphasis on community involvement, with the Division of Psychiatry playing a major role in this thrust of the Center’s effort. Has the forthcoming

Commonwealth of Massachusetts-B. U. Community Mental Health Center influenced your thinking and geared your efforts to the community?

A. Yes, it has for the last thirteen years, because it is called the Community Mental Health Center. If you put the emphasis on the word community, then you have to think what is the community, who is the community? Community is more than people in census tracts or people who are in epidemiological studies . . . they’re human beings living in their environment . . . they’re citizens, they’re neighbors; and then you have to understand what the whole structure and organization of the community is. You also discover, at least I discovered, that I didn’t know anything about it. I went through it on my way to work and I went through it on my way away from work, usually as quickly as possible, and if I could detour it the better. So there has been a — really, not only for me but, I would say, for everyone in psychiatry it’s been a tremendous effort to learn about the community. That’s the first thing.

Then when you approach the community, as we did in the development of the mental health center, to get advice, it’s crucial to learn who were some of the significant people in the community . . . and when you turn to them for advice you have to ask yourself, are we planning FOR the community, delivering services for which the community should be grateful, or
are we going to plan WITH the community? If you're planning WITH the community you are doing something new, you're beginning to share power... you're beginning to work in a democratic process involving you and the community. Now in the sharing of power, that means that if you're planning WITH, the other person has something to say and you're yielding a certain amount of authority; you can't arbitrarily say, "now, I am the boss... it's going to be my way."

Q. Why is it in the Medical Center's interest to give up authority and share power?

A. I won't speak for the Medical Center... I will talk about the Mental Health Center, and I'll talk about the Division of Psychiatry. I think that we're living in a world in which a great many people feel alienated... they feel they have no part in the process of decision-making... they have nothing to say whatsoever about the decisions that affect their lives... they live in communities, but they have nothing to say about what happens to that community... it's all determined by impersonal forces, by people with other interests and other axes to grind. Now when you are talking about community and a community mental health center whose responsibility is to the community... why shouldn't the community have a very decisive say about its needs, its requirements, and about the personnel who are going to be working with it, and about policy, and about programs?

This country is developed out of community. I think the great strength of this country before the Revolutionary War was that we had communities in Concord, we had communities in Lexington, we had communities in the South, and communities in Philadelphia... and the communities developed, really, our whole democracy. They developed our educational system, they developed everything I can think of that's of real value in democracy. What we've seen in this country is the gradual extinguishment of community so that people, I think, are increasingly living in a very impersonal world.

If we ever are going to achieve true democracy, I think the hope lies in a restoration of community in this country. Now I think the key problem in this country is the problem of urban cities, to say nothing new, and the problem of the black community... the poor, but particularly the blacks because of the greater number... 10 to 20% of our population who are living in the urban cities which is community. So are black people to be part of democracy or not? Which means are black people going to have a basic say about the determination of institutions that serve them? Now the traditional way of thinking for mental health center people is to talk about the community as OUR catchment area... 155,000 people in my catchment area... I'm responsible for them on my nice big plantation... mental health plantation. Now I don't think that's reality. Model Cities is a reality and I think that embodies the idea of community; of course it is tangled up with all sorts of community agencies because then what happens about the police, and what happens about welfare, and what happens about the school system. And the community having something to say about its schools... we who have our children at private schools do it... we have a lot to say about the private schools, and people who live in Concord and Lexington and other towns have a lot to say about the school system. So, this is really what gives meaning to life and I think this is the basic problem of democracy and I think, this is where I am taking quite seriously, community in Community Mental Health Center.

Q. Will you be able to maintain the high quality of services if you bring in, at the community's request, non-professional community people to run the Mental
Health Center along with the professionals?

A. I'm not sure the professionals won't be running it, since the state requires that the director be a psychiatrist, and also the Director of the Consultation and Education Program, and by law there is to be an area director for this area and I think by law, I'm not sure, but I think it has to be a professional. But nonetheless, I'd like to respond to two points in what you said.

First, about the trained professional. I think the trained professional has a fantastic amount to learn because the trained professional is trained for a different world from the world in which we are living. The trained professional is trained in order to provide for private practice, he was trained to work within a hospital which was not responsible for the mental health of an area; his problem is, now, how does one take care of the organization and distribution of health services which will assume responsibility for a whole section of community. This has not been the training of any professional except in the last few years. Lastly, there has been no relevant training of a professional. A person going into the State Department learns something, theoretically, about the country to which he is to be an ambassador; he has to learn his language, and he has to learn his customs and background and history. When we work in community and in black and urban communities we are ambassadors to a very different world... and if we think we know the language of this world and the values of this world and the customs of this world, we are kidding ourselves 100%!! So that the trained professional has an extraordinary retraining job to do on himself, and it isn’t always easy for people once they are trained, because they “know all the answers.” To be humble and admit ignorance and to have

to learn again and to change is difficult.

And then, people in the community, although they haven’t got traditional training, have a great deal of knowledge. Untrained people organized a board of extraordinary competence for the Roxbury Comprehensive Health Center and passed on personnel and negotiated with the University and with President Christ-Janer. These untrained people, in addition, were sufficiently important so that when I was chairman of a committee to find a professor and chairman of community health, what determined Dr. Dave French to come here were these untrained people; it was the nature and strength and quality of the community. So I would say that these untrained people have an extraordinary amount of knowledge and expertise and have a lot to teach us.

Carl Franzblau, Ph.D.
Associate Professor of Biochemistry,
Boston University School of Medicine

Q. You’ve been one of the active faculty members helping to open the Center up to opportunity for members of the black community. Tell us about the summer project for college-bound students.

A. Well, it’s a very simple idea. We’ve chosen a very small, selected group of high school graduates in the community who are going on to neighboring colleges and we’re helping to provide enrichment for them in the areas of science, reading and mathematics. With the help of Health Careers, Inc.,
help them, you can at least show people that there are possibilities and hopes that they can go to medical schools... that they can aspire to be physicians. I remember a student saying that he never went to a doctor who was black, so he could never except to be a doctor himself. So that's pretty much... that's the number one responsibility. Number two is to provide care for the neighborhood and make the neighborhood aware of the medical center.

We've taken ten students who are given individual laboratory jobs in the afternoons for which they are paid; in the mornings they have instruction. Each week on Monday, Wednesday and Friday mornings we have another faculty member from the Medical Center teach them about various areas related to medical sciences. Dr. Pelikan has talked to them about blood pressure and cardiac problems. Drs. Cain and Ullrick have talked about physiology in general, Dr. Ifft histology and anatomy, and Dr. Smith and I are dealing with basic chemistry.

We have in addition given a first-year medical student a summer fellowship, and he is essentially in charge of the total program. On Tuesdays and Thursdays, Health Careers take the students to their own offices for enrichment in reading comprehension, reading speed skills, and so on, in addition to elementary mathematics. The students seem to enjoy the program, and we hope to be able to find support for it next year on a much larger scale.

Q. This is an important instance of the Center's increasing involvement in the community. In the broadest sense, how do you see the Center's role in the community?

A. I think that a medical school is not just a place to teach medical students, but it has a very active responsibility... a social responsibility... to the total community. It has got to train black physicians, let's face facts. Secondly, it's got to be aware of the community around it. It's got to be aware of the community, provide health care for the community. The community should feel that the medical school is part of the community, and it certainly doesn't now. But if it sees that we're bringing in their students from high schools to

Louis W. Sullivan, M.D.
Associate Professor of Medicine,
Boston University School of Medicine

Q. You were one of the leaders in the move to attract qualified black students to BU. What was behind this effort and how successful has it been?

A. I was one of three people primarily here on our medical school staff who were interested in this problem. The others were Dr. Carl Franzblau in the Department of Biochemistry and Dr. Edgar Smith, also in the Department of Biochemistry, and himself a black biochemist. We were talking really about the fact that though Boston University has for many years had the image of a liberal institution... and I truly believe that this has been the essence of the philosophy here at Boston University... I think that for too many years the Medical School had rested upon the fact that it was a liberal institution and taken it for granted. And other institutions which haven't been so liberal in the past,
and particularly the Southern medical schools which now have opened up their classes for black students, have been vigorously and aggressively recruiting black students. Therefore, Boston University, which did not have an aggressive recruitment program, was not getting the applicants that we used to get, so that last year we had a total of three black students in the whole school. We thought that this was really not an accurate reflection of the concern that Boston University has had traditionally for the socially disadvantaged, including the black. We felt that something needed to be done to rectify this situation.

Well, we did, through the efforts of my two colleagues and a number of other people who participated, many of them students who helped in various aspects of this effort, organize a weekend program where we invited a student from each of 23 black colleges predominantly in the South to visit us so that they would really have a chance to look over the medical school and learn of our concern and the concern of the School in general to have more black students, and would hopefully then apply. And as you know, we also invited the other New England medical schools... Dartmouth, Harvard, Tufts, and University of Vermont to participate and they did.

In terms of how successful this was, I think that as a beginning effort it has been moderately successful and I say moderately successful because of the fact that we have six black students in our freshman class this year... five of whom we might say are a result of this recruiting effort. These six students are out of the total of 96 in the freshman class, and this represents a significant improvement over what was the case before. It still doesn't begin to become the effort which needs to be made on the part of all medical schools here in the country to really make up for the tremendous deficit we have in black physicians in this country.

Now by that I mean this. In 1940 there were something like 2.2% of all physicians who were black and in 1966 only 1.9% of all physicians were black... and the statistics in terms of the number of black physicians per one thousands of black persons in the United States has fallen significantly rather than having kept pace. So in terms of a population ratio basis we've actually fallen behind... it has been estimated that there are around 5,000 black physicians presently in this country and if we were to assume that one should expect to have parity in terms of number of black physicians in relation to population then there should be 30,000... so in other words we have one black physician for every six we really should have.

Now one of the questions here that many people will ask, of course, is why this ratio... why do you say that since 11% of the population in this country is black why should there be 11% black physicians? Well, I'm not saying that it should be 11% or 5% or 20%, but again from a realistic point of view, this School has existed for many years turning out graduates who go out to practice... these graduates haven't gone into Roxbury, they haven't set up offices there... they've gone into the suburban areas and also over in the Back Bay region here in Boston and this is where they've set up their offices... so I think historically this group has not produced physicians who have practiced in the Roxbury or the ghetto area, and thus to the degree to which they have been removed geographically they have been inaccessible to the black community. And so therefore it is our thesis that one of the most promising means to increase the number of physicians available to the black community would be by increasing the number of black physicians who because of their own recognition of the need for physician services will elect... some of them, though not all... will elect to go into the black community and practice. I don't think we need or should impose any restrictions on black students entering because they are human like everyone else... some of them will want to practice in suburban areas, some will want to do other things, but I think that...
the likelihood, with the awareness in the black community as well as the community at large and the pride in the black community is that a substantial percentage of them will be attracted to the black community. And another thing of course is that many white physicians who have some concern for the black community have expressed doubts as to whether they would be welcomed in the black community with the current status between black and white relations in the country. So I think that from all of these standpoints one can easily justify the emphasis of getting more black physicians.

Q. You've been a part of the University Hospital family for so many years... How did you become involved with the Hospital?

A. My father and his closest friend were Trustees when the Treasurer moved up to the Presidency in 1927, they needed someone in the financial business and asked me to serve... I was 28.

Q. Would you ever have foreseen that your relationship would be so intense and of such long duration?

A. No, those were exciting years, not only for the hospital and because of the tremendous developments in medical research, but particularly in my field of interest which was medical economics, the way in which medical service is provided and paid for. Much has been accomplished in this all important area although I'm afraid more in theory than in actual application.

Q. What would you say are some of the highlights of your involvement here as you look back over the years?

A. Well, one was certainly the symposium of 1955... Health for the American People... with which we celebrated the Hospital's Centennial. Leaders in various fields of medicine attacked the problems of cost and availability of medical care with conclusions that are strikingly relevant today. Another, of course, was the formation of the Medical Center whereby the fullest measure of cooperation between Boston University School of Medicine and University Hospital became possible.

Q. What changes in the Hospital have you noticed that stand out in your years of service?

A. Well, I suppose the physical changes. Of the hospital buildings in 1927... and there were five... only one now is used for its original purpose. Two buildings have been constructed and one enlarged. And now we have the great new Evans underway, the Betatron, the Doctors' Office Building, and the Medicenter completed. Answering your question about changes, however, I must say that the most noteworthy thing is the fact that there has been no change in the priority of concern for patients as individuals, not cases.

Q. What changes would you like to see at University Hospital and at other urban teaching institutions in the near future?

A. I hope and expect to see even greater involvement in community health. I would like to see a comprehensive prepaid health insurance plan sponsored by all hospitals in the Greater Boston area. A development which seems to me long overdue.

Q. You've given so much to University Hospital, it must have been a meaningful experience for you.

A. Well, it certainly has been a rewarding experience... which is to say that I have received far more than I have given. I think the principal reward has been the intimate association with an extraordinary group of men and women... doctors, nurses, workers in all categories of unique dedication. This has been a continued inspiration for me.
Q. The Medical Center is extending its medical and surgical residency programs into predominately community hospitals through the Center's affiliates. What benefit does this have for the Center and for the community hospitals and their communities?

A. Well, the picture of the Medical Center of the future involves the concept that we are not merely concerned with an ivory tower type institution, but that what we do, both in terms of teaching and of carrying out research, must relate rather closely to the actual delivery of medical care to the population. For this reason it is essential that the Medical Center have connected with it a large number of community hospitals and other medical facilities concerned with delivering medical care to the usual types of American communities. Then, there is a distinct advantage to the Medical Center to have close ties with community hospitals in order that medical students be exposed to the type of medical problems and get a view of medical practice in communities of the type in which they are likely to practice. The types of diseases which are seen in the general practice of medicine are different from what one sees in a medical center in which large numbers of patients are referred from over a large geographic area, so that the concentration of unusual diseases is extremely high in medical centers. This gives the medical student a rather false concept of what he will actually face when he enters medical practice. In addition, the research in which there is considerable interest in medical centers, where unusual diseases are seen, tends to concentrate on the more unusual, rare diseases and very often leaves untouched the vast majority of more common illnesses which are really the major problems in this country.

As far as the communities themselves are concerned, their advantages in being part of a medical center are several. The major criticism that has been concentrated on the medical profession in recent years is the failure of physicians in practice to keep abreast of the more recent advances in medicine. In a setting of medical teaching, particularly with the exposure to medical students, residents, and interns, there is a constant inquiry on the part of these younger individuals as to the rationale of treatment, the correctness of diagnosis and so on... all of which keeps the physician who is exposed to this kind of medical practice on his toes. The net result of all this, therefore, is the delivery of a better grade of medicine by the physicians and other staff members in the community hospital and the elevation of medical care in the communities that are so associated.

Q. How does this program of affiliations tie into the concept of regional medical programming?

A. One of the major concerns today in terms of delivering high quality medical care to all the people in the country relates to the fact there must be some program of continuing education, not only of the physician but of all the people in all the health professions. We think in general that the basic education and training of most of the people we prepare in the United States is as good
if not better than anywhere in the world. However, there has been very little done to guarantee that the high caliber of education and training is maintained. There are many programs for this type of continuing education activities . . . this is one of the major concerns of the regional medical program . . . how do you deliver good medical care to everybody in the country? You do this by presumably first of all making sure that you have the quality of people prepared to deliver the service or in other words . . . excellent physicians, excellent nurses and so on.

The major thrust of the regional medical programs has been, and I think will continue to be, of an educational nature; what programs can you have that are going to continue to improve the health worker so that he delivers the same high caliber medical care that he did when he first got through his training? In medicine, this is very difficult, because most surveys of such things as television programs aimed at the physicians, circuit-rider type of visits by professors from the medical centers, and symposiums have shown them as not really very effective. What is required in medicine is almost a one-to-one kind of teaching-training experience in the atmosphere of the patient. Probably the most effective continuing education program is that in which the patient's own physician is present, concerned with the problem which his patient has. This problem is then considered in terms of a teaching situation in which the medical students and house officers are concerned about learning about this disease and then someone more expert in the field is available to discuss the whole problem; then the teacher, the patient, the patient's physician and the young trainees are all together. This system certainly appears to be the most ideal one for the continuing education programs. This is really what one is trying to do in all these community hospital affiliations in which one tries to develop training programs.

Richard H. Egdahl, M.D., Ph.D.
Professor and Chairman, Division of Surgery,
Boston University School of Medicine
Surgeon-in-Chief, University Hospital
Associate Dean for Hospital Relations, Boston University School of Medicine

Q. Dr. Egdahl, since you came to the Medical Center in 1964 can you tell us some of the goals of your program in surgery and whether you feel you have achieved them?

A. Well, I think we have achieved some of them. One of the main goals and the first one really was to get a geographic full-time staff to add to the strong clinical heritage that Dr. Smithwick left. We have several key Department members who are very strong in the clinical areas, and what was needed to bring it up to a well-rounded department was a group of individuals with research interests in addition to their clinical interests. In addition to Dr. Mannick, Dr. Jackson, now Dr. Hechtman and Dr. Rutenburg serve to bridge that gap between the clinical and the experimental, and I think that the concept of having several strong areas of combined experimental and clinical activities such as exists in medicine is the one that we believe in. In surgery the areas are: fetal surgery, pulmonary physiology, transplantation immunology, experimental endocrinology, gastrointestinal research, infections in wound healing and others, and certainly the specialty areas, that had to be developed and we now have growing departments in several of the specialties and will have
the others in the future.
I'd say the first and major goal was to add research and other strengths to an already strong clinical heritage. I think that basic to that was to acquire a certain minimal amount of space and research funding, and we have been modestly successful in terms of the research support that these people have. With the staff it now becomes possible to do a better job in teaching medical students and the residents and to perform all the educational functions that actually constitute our major mission in the Medical Center which is education, graduate and post-graduate, at all levels.

Q. You were responsible for the establishment of one of the first programs in Academic Surgery in the country. Where does this stand right now?
A. While we were not the first to establish a training program of the sort that was funded by the NIH for training academic surgeons, in terms of funding, our grant I think was the largest to date for developing a program that would design from the outset to fully fund a person who had decided to go into academic surgery. We now have this program developed so that it embraces eight academic trainees. Next year it will be ten and the final year twelve. It will stay at that level — twelve people in the program at any one time. This funding provides money for faculty salaries, for some of the research, for trips to meetings and for the personal stipends for the entire period of their training for the trainee. It permits them to enter this program if they want to go into an academic career and not suffer the competitive financial disadvantage that they often have when compared with their counterparts who have completed training earlier and gone out into practice. It provides a prestige item in addition to the financial buttressing for the research and other activities of the trainee and has made it possible for the Department to add new faculty members to help in this program that would not have been possible without the award. There are several other programs like this around the country. Over twenty actually, but I think ours is one of the two or three largest and the success of course depends upon our continued input of high quality young men who desire careers in academic surgery.

Q. During this year you have been named Associate Dean for Hospital Affairs and you're concerned with the Center's links with its affiliated hospitals. Can you tell us the significance of this development? Why does a major teaching center need affiliates?
A. There are the first and rather practical aspects to it. That is, if you are going to have a major university hospital it has to have a broad spectrum of patients that are representative of a variety of conditions. This is necessary for the hospital's mission as a prime university referral center both from the standpoint of staff and the graduate student or residents or medical students. Even more important, I think, is the fact that the concept of medical education and of the role of the medical center has been expanded from that of a relatively ivory tower institution to that of the partner with various communities in the evolution of their health care delivery schemes of the future. We are engaged in a great national debate as to what scheme of delivery of health services to the population of the country should exist in the future. I think it's becoming apparent to most that change will occur. Most of us also feel that we would like to preserve as much individuality, have as much pluralism in the style of care delivery as possible or consonant with the needs of the public.

In order for the Medical Center to be able to provide an arena for our students at all levels, undergraduate, graduate and post-graduate to participate in, we have to have various slices of the real world. A university teaching hospital does not represent the kaleidoscope of patients seen by the practicing physician in the community hospital, as has been so aptly pointed out by many, and for that reason we have to have high-quality community hospitals for these various students at different levels to study and to react with. Furthermore, we have to have areas where other components of the University . . . Law School, Theology School, Sargent School, Nursing School . . . can participate in order to stay up to date in terms of developments and in order to have places for field work for students at various levels.
What we get from it, therefore, is a certain spectrum of unusual cases in terms of the university hospital and places for our students to be taught. What the community hospitals and regions that participate with us in health care planning get is the fire-power of the University at all levels in terms of the evolution of background data, hard core facts, bringing of new knowledge as rapidly as it is found out and teaching at all levels. So it is a mutually beneficial partnership which works to the advantage of both groups and in terms of the complex federal financing or state financing that is going to be involved, it is going to be essential that we have partnerships of this sort if the monies are going to be forthcoming. The single greatest lack in many areas of the health care delivery schemes that have been proposed to date is lack of financing. If we are going to exert or have any chance of exerting enough leverage to get the kind of financing necessary to do the job, it’s going to take the combined efforts of the university medical center, the community hospitals and the community as a whole.

Robert W. Wilkins, M.D.
Wade Professor and Chairman, Division of Medicine, Boston University School of Medicine
Physician-in-Chief, University Hospital
Director, Evans Memorial Department of Clinical Research

Q. How is construction on the new Evans progressing?
A. The new Evans building is again going up after a strike-delay and is now scheduled to open in February 1971. When completed, this building will mean about a doubling of space for the total Evans program. Particularly important will be the space for 83 new medical beds which will increase the hospital’s total bed capacity by 25 percent and the beds for Medicine by over 50 percent. Space for clinical research laboratories will be increased by more than 100 percent.

Q. How will the new building affect the Department’s activities?
A. This great increase in facilities will mean much more effective care, teaching and research activities by the Department. All the new patient rooms will be either private or semi-private . . . that is a double room . . . and will be equipped with the very latest of modern apparatus. They should indeed be popular for patients who need acute hospitalization. Likewise, the new Evans areas allotted to nursing and to education (for both nursing and medical students) will be much more commodious and efficient than anything the Department has ever had before.

The enlarged new research areas will accommodate not only the old research sections for our 18 sections more effectively, but also permit several new sections . . . at least three . . . to be devoted to areas of research not now being undertaken. Situated between the Medical School and the Hospital, the new Evans building will supply both geographically and symbolically the connecting link making BUMC a single continuous medical center.
Q. The installation of the world’s most powerful Betatron this year, and its dedication, was probably one of the major events in the Medical Center. Have you had many inquiries about the facility from patients and doctors?

A. Initially we had quite a few, it seems to have tapered off a bit. We’ve had letters and inquiries from all over the country because the announcement was carried by United Press International news service, Associated Press and national television. The unfortunate part or the disheartening part is that I have received phone calls from families... whether it’s husband or wife or child that’s dying... who wanted to know if the Betatron would cure them and I think that because of the large publicity that it did get and because medicine was so excited, the layman thought it would cure cancer. I think that it is great that we do have the Betatron, but very unfortunate for those people who are just grasping for the last bit of hope and thought this would be the answer and unfortunately, it wasn’t for their problem. Dr. Aral has received quite a few inquiries from surrounding hospitals in the area about our facilities and we will be open to every physician in Massachusetts who would like to send patients.

Q. Is there anything special about University Hospital?

A. Yes. Before I came to the University I used to have a job about every four or five months. The University... especially initially because it was so small when it was Mass. Memorial... it seemed like everyone took an interest in each other and it wasn’t separate department interest... we worked as an entire hospital and after working in five other hospitals I found this extremely refreshing. We do have lots of problems here... problem of communication is one of the largest and I think we’re having growing pains... we’re in the midst of coming into a great University Hospital and Medical Center.

I think in the radiation end of it... from what I’ve seen of the other Radiation Departments in the city of Boston... that University Hospital has to be if not the best, one of the best... it is definitely second to none... and that’s treating the entire patient... not just the radiation treatment... I think it’s taking care of the whole patient and the entire patient’s problems and this is where most therapy departments lack. In most hospitals, a patient is treated by a part-time radiologist and a part-time radiotherapist and the technician is a rotating x-ray technician, who unfortunately has had only one month of training if she’s ever had that... and obviously the patient suffers. It’s something that University Hospital has that people feel; it’s like working for the family and not just a job that you go home and forget about.
Mrs. Carol H. Washington, R.N.
Supervisor, University Hospital

Q. Your family has a tradition of service here, doesn't it?
A. Yes, there are five of us...two other sisters, and two cousins, so that makes five of us in all.

Q. What are your responsibilities now in the Hospital?
A. I am now acting supervisor of Robinson and Collamore 4. I'm supervisor of these two floors and responsible for the patient care.

Q. Do you feel that there is something special about University Hospital?
A. Well, I think I'm a little bit prejudiced because I am a graduate, but I have always liked it because of the friendly atmosphere we have here, and because we're a teaching hospital, too, I think. It's friendlier here; the patients are well taken care of because the doctors and nurses seem interested in the patients. We do a lot of teaching and research here, but I think the patients do come first.

Henry J. Bakst, M.D.
Dean, Boston University School of Medicine
Professor of Preventive Medicine, Boston University School of Medicine
Health Conservationist-in-Chief, University Hospital

Q. Dean Bakst, has the unrest among the nation's students reached the graduate level?
A. Well, there is some unrest at the graduate level, but as I see it, I think the kind of unrest is different from the sort of thing which is going on in colleges at the undergraduate level across the country. Students at this school are obviously more concerned about things which students some years ago apparently were not concerned with. One area is in relation to the curriculum of the medical school, and their desire to see greater involvement in community health problems than in the past. Most of our entering students don't appreciate the fact that this medical school has had an on-growing concern and involvement with the problem of community health ever since it was first established. On the other hand, the students themselves want to be personally involved in this kind of activity and want it to start as early in the curriculum as possible.

A second concern on the part of the students is desire to participate in the operations of the school, and this seems to be an entirely justified position to take. Students have requested appointments to various faculty standing committees; the medical school has agreed to do this, and this has now been going
on for the past two years and quite successfully. Students participate as members of the executive committee of the faculty, as members of the admissions and promotions committees, and a variety of other committees as well.

The students are also concerned with problems of their evaluation by the medical school and have raised questions as to the desirability and the usefulness of a single testing procedure at the end of the year. Their feeling is that evaluation of the student, particularly in terms of his clinical activity, should be on a direct and personal basis in terms of how effective the student is in discharging responsibilities in dealing with patients and developing plans for patient care and so on. And the sub-committee of the executive committee will probably deal with this problem as its initial issue at the beginning of this school year.

Q. Has the development of the Department of Community Medicine been the result of student pressures for more community involvement by the School?

A. No, the development of the Department of Community Medicine had nothing to do with student pressures... actually this change of the name of the Department of Preventive Medicine had been given consideration over a long period of time because of the need to reflect more adequately the activities of this department to indicate the interest in the problem of the delivery of medical care services, to emphasize the importance of such activities as the Home Medical Service and the new program in Roxbury, the neighborhood health center. It still retains its responsibility to transmit to students the basic concerns and problems that have to be dealt with from the point of view of preventive medicine also.

Q. What effect has the new Instructional Building had on the teaching programs at the School?

A. The Instructional Building has had a very significant impact on the curriculum in several ways. First of all, the decision was made to establish home-base laboratories so that a student in the first year is assigned a bench in a laboratory which is then used for all the basic science teaching — except for gross anatomy which requires a separate area. A similar arrangement has been made for the second year, and this has decreased thereby the amount of laboratory space required, since it is geared to the individual student rather than to the discipline concerned. So instead of having a laboratory area for each basic science department... these are all joined together in the first and later in the second year to provide individual space for each student. This has an advantage obviously in reducing the amount of laboratory space needed; it also has a significant disadvantage in that growth in terms of increased enrollment is sharply limited to the amount of space made available. So when we increased our student body from an admission class of 72 to 96, spaces were provided for 96 students... and at this point it is extremely difficult to go beyond that level in the admitting class. And to increase significantly the size of our admitting class at this point means inevitably that we will need new construction.

The image of the School to a certain extent has changed as a result of both new facilities in which to study and to work; of course one should also include in this a new library... attractive, adequately staffed, expanded enormously in size from approximately 2,500 square feet which we had in the past to 30,000 square feet, with capacity for 100,000 volumes and 1,600 periodicals and visual aids of all kinds. This may have some significance in relation to the admission situation in September of 1969 when we received approximately 1,400 applications for 66 positions. This means a ratio of approximately 20 applications for each available position, with an unusually high caliber of scholastic achievement on the part of many of these applicants.

The student grapevine is a very successful one, they seem to be aware of where changes have taken place and where the place to apply is and we seem to be benefiting as a result of both changes in curriculum, in relationships between faculty and students, and in physical facilities.
Q. You have been Chairman of the Medical Center since 1964. Has the development of the Center, both programmatically and physically, been up to your expectations?
A. I would say that the physical growth has been nothing short of phenomenal and I am encouraged by the many significant programs which have been generated at the Center. For instance, our surgical programs with what are essentially community hospitals. Yes, I am happy to be part of this extraordinary Medical Center.

Q. What do you see as the greatest challenge facing our Medical Center and probably other centers as we enter the '70's?
A. We must find some way to check and hopefully reverse the spiralling costs of producing doctors.

Q. How do you envision doing this?
A. Any institution or corporation must, from time to time, evaluate itself and the time for such an evaluation has come for the Boston University Medical Center. We now have underway the Chapman study, so named for the Chairman of the Committee, Richard Chapman. We hope that it will give us all a better insight into our own organization in such areas as finance to the actual organization of programs. When completed, the study should give us valuable information about ourselves and will provide us with guidelines for action we should take in order to improve efficiency, and thus to reduce costs while increasing productivity. We are grateful to the Commonwealth Fund for funding this study and hope that this information, when compiled, will assist not only the Boston University Medical Center but other medical centers as well.

Gerhard D. Bleicken
Chairman, Boston University Medical Center
Trustee Council

Henry M. Goldman, D.M.D.
Dean, Boston University School of Graduate Dentistry
Professor and Chairman, Department of Stomatology,
Boston University School of Medicine
Stomatologist-in-Chief, University Hospital

Q. What is the philosophy of the School of Graduate Dentistry?
A. When the School was started, it had a basic philosophy of dedication not only to dentistry as such, but in reality to the oral cavity. There was an old Department of Stomatology at what then was Massachusetts Memorial Hospitals and now is University Hospital. This theme was stressed: mainly that we would be interested and concerned with not only dental diseases but oral diseases, namely, those that are oral manifestations of systemic disease. So that we really are dedicated to and even reinforce the idea that the School would be one that would entail the broader phases of all medicine or stomatology.

Q. Can you tell us about some of the significant research that's being done at the School?
A. I'm very proud of the staff and especially
concerning the research that's coming out of the Dental School . . . it is wide and varied . . . and certainly is basic in nature. As I indicated, our school is not dental alone . . . and therefore this is reflected in our research. Actually, the School does very little research in decay of caries. Most of our research is concerned with general biologic basic research. Therefore, we have people like Dr. Wells, Dr. Fillios, Dr. Henriques and Dr. Ruben and a host of others who are doing research on its highest level. We do a great deal of research in periodontal disease because this lends itself as well to basic research. We have been fortunate in getting support from the National Institutes of Health . . . and in fact this last week we received somewhere around $850,000 over a five-year period, only in that week. We have also been fortunate to get research fellowship money . . . and we now have a Ph.D. candidate in Periodontics and one in Endodontics. These programs are being enlarged at the School.

Q. It is interesting to hear about the Ph.D. candidates . . . are you planning to do anything further along these lines?
A. Yes, we are, in conjunction with the Graduate School, setting up a program for dentists leading to the Ph.D. degree. We have established an Oral Biology section which will be under the Division of Medical Sciences. We hope that this will attract a number of dentists to seek education in the basic sciences leading to the Ph.D. degree. This is a program to be headed up by Dr. Fillios from the Dental School and under Dr. Ruth Levine who is Director of the Medical Sciences of the Medical Center and the Graduate School.

Q. Do you have plans for any other programs?
A. Yes. As you know, the Dental School which is really a graduate program, sponsors three programs leading to a certificate in graduate studies, the Master of Science Degree in Dentistry and the Doctor of Science Degree in Dentistry. It has been the thinking of the Executive Committee of the Dental School that we should establish an undergraduate Dental School here at Boston University. There are many reasons for this; a proposal has been sent in to the Administration for their consideration.
have been at the hospital and before they come, they have a certain expectation; I feel this expectation is fulfilled for most who are trained at University Hospital. We have particularly strong programs in almost all of the branches of medicine, medicine itself, surgery and psychiatry, of course, and the various surgical sub-specialties, all of them have certain strengths in and of themselves, and my impression is certainly that house officers here feel that they get the best training that they could possibly get in their field.

Q. Do you feel that our affiliations and the programs we've worked out with them are helpful to house staff?

A. Yes, I do. Most definitely. In medicine . . . the department that I am most well acquainted with, the experience of training at both Boston City Hospital and the Veterans Hospital as well as University Hospital is invaluable. It's obvious that the type of patients in many areas . . . the type of disease . . . that is seen at an institution like the Boston City Hospital is somewhat different from that experience that we have here at the University Hospital; and I think both of these aspects are important in a house officer's training. In surgery, this is particularly important in that the emergency room facilities at the Boston City Hospital give him a real chance to deal with these problems. Cases involving trauma and other acute emergencies are handled quite well in an emergency room setting, and I think that this becomes a vital part of our training. In addition, the training that we get in some of the smaller facilities . . . at least from a surgeon's point of view, in hospitals like Chelsea Naval Hospital and the Providence Veteran's Hospital are invaluable additions to training as well.

Q. What are some of the strengths at University Hospital from a house officer's point of view?

A. Well, there are many strengths. The first one that comes to mind and the one that stands out most vividly, I think, is the relationship that the house officers have with the teaching staff . . . both the full-time teaching staff and the visiting teaching staff; from my experience this is one of the strongest aspects of the house officer's training program here. In other words, when problems do arise to help you better understand the problems your patient might be having or just to increase your knowledge of their disease or the problems that arise with it, I've always found it very easy to find staff people and I've invariably found them very receptive to my questions. They're here all day, of course, willing to answer questions, see patients with you, even if they are not directly concerned with the patients, and help you in any way that they can. In addition, these staff people are always available to call at night and for any help that you might need when you have a particular problem with your patient, and this is what impressed me as a student here at this hospital . . . that is, the very fine working relationship between house officers and staff people. And through my training, I found this to be so.

Q. Dr. Bailen, what's your feeling about the caliber of house officers that we are able to attract?

A. I feel that we are attracting a very high caliber of house officer. In some of my elective time, I've had experience at other teaching hospitals here in Boston and I found that the University Hospital's interns and residents are equal to if not better in their knowledge and their ability to deal with patients than in the other medical centers with which I've been acquainted. I think that attracting good house officers is a very important part of our education in that a great deal of our house officer training comes from our relations and learning amongst ourselves. And while some of the, most of the, didactic teaching, and teaching on rounds, of course, comes from staff and attending people, we do learn a great deal from house officers, both at our own level and at levels above us and I suppose from medical students and interns, people who are a year or two behind us. I think all of these people contribute to the total educational experience and I think we all stand to gain a great deal in keeping a high caliber of house officer in various training programs.
What attracted you to Boston University?

A. The Six Year Medical Program was an exciting concept... the concept of eliminating the standard large classroom atmosphere which most urban universities face; having a group of selected, intense, and sometimes over-intense, young people together for one program that was oriented both toward liberal arts and medicine. This I thought was a unique feature of Boston University's Six Year Program. There are other programs at Northwestern and at Jefferson Medical Center which are combined undergraduate-M.D. programs, but they emphasize science to the exclusion of the liberal arts. I was able to take almost three-quarters of my courses in liberal arts programs... there was that much freedom.

Q. Has B.U. lived up to your expectations?

A. In almost every way. Mechanically, the program is very well designed... the Medical School and the Medical Center are oriented towards people as human beings... however, there are, as in any institutional process, there are some problems. Some of these include the need to educate large numbers of people, so that the individual problems cannot be focused upon; the individualization of curriculum has not yet come to Boston University as it has to some medical centers like Ohio State or Western Reserve or University of California at San Diego where the curriculum there is a good deal more freedom of choice on the graduate level, much the same as on the undergraduate.

Boston University is an exciting clinical place to learn medicine... it realizes the need to turn out professional competent clinical physicians and its goals have been well realized both... to my understanding... both in terms of examinations, where Boston University on the clinical fourth-year boards has placed very highly in the last four or five years, and personally it is a very rewarding place to be... because there are excellent teachers in the undergraduate science courses. Some of the outstanding people would be Dr. Carl Franzblau in the Biochemistry Department, Dr. Ullrick and his kind of very personalized one-to-one teaching in the Physiology Department; Dr. Corwin in the Microbiology Department; Dr. Robbins is an outstanding lecturer and very interested friend, teacher, tutor and physician... so in the basic sciences, Boston University is exciting. In the clinical sciences, it is equally exciting with men like Dr. Alan Cohen and Dr. Murray Freed and Dr. Egdahl, Chairman of Surgery... he takes a good deal of time with the third and fourth year medical students... so it's a very rewarding place.

Q. You feel that the faculty really cares about the students?

A. Yes, very much.

Q. What do you see as some of the strengths here at the Medical Center?

A. That the Medical School is closely associated with the Medical Center and an important part of it. That the medical education process is a clinically-oriented process or procedure. That there is student involvement in that there is a very rapid feedback... very intent listening on the part of the administration to the students and the way they feel. That many Boston students stay in or associate with the Medical Center... in clinical practice and are willing...
to come back and feed back to the students. And that the department chairmen are also, as is the administration, very receptive to the student feedback; they are constantly trying to upgrade and improve the caliber of the student, the education, and the intern and resident training programs here. Also that there are attempts being made to integrate medical, intern, resident, and post-graduate educational processes because it's really one continuing process not several separate ones. To me these are among the big strengths.

Edward McCarthy
Custodian, Boston University School of Medicine

Q. Eddie, what is the most important part of your work here at the Medical Center?
A. What's important to me is getting to know my students . . . personally, their likes and their dislikes. Someone has to take care of them, so I feel it's my part to do it. I check on them when they have appointments, I see that their mail is taken care of when they're away, I know all their schedules so I can tell them what's their next class.

They can find me almost anywhere in the Instructional Building. In the winter time, I'm here six days a week sometimes. If they need help on Saturday, I'm there. This year the outgoing class gave me a BU chair. And when it was presented to me, I was so shocked, I couldn't speak. I just sat down and said, "I can't talk."

I keep in touch with the students after they've graduated, and they come back to see me. I'm interested in how they're doing, and if I see any of their classmates, I'll ask, "Well how is so and so doing?"

Once in taking care of some of my students . . . I had a boy, he couldn't get up his freshman year . . . and I used to call him every morning at 6:00 a.m. so he could arrive in time for classes. I'd say "Good morning, Robin, it's now 6:00 . . . stay up!!"

I'm here at 5:30 a.m. and stay until 5:30 or 6:00 at night. It's a long day, but I enjoy every minute of it. Time goes fast when the students are here. I'm with my students four years . . . I'm the first one to meet them, the last one to see them go, at graduation. And I've enjoyed every minute of it.

Florence E. Turner
Librarian, Boston University School of Medicine

Q. After years of dingy and cramped quarters, you've blossomed into a luxurious spacious setting. What has been the reaction of the students, faculty and alumni?
A. One alumnus was visiting the other day, and I took time to walk all over the Library with him and he was saying,
"Fantastic, fantastic, fantastic!" This, to me, is always a very extravagant word, but when I do look back, and remember the very, very cramped quarters we were in and the difficulties under which the staff worked, as well as the reading community, I can well understand how he can say, "fantastic, fantastic."

Q. What's been the percentage of expansion?

A. I think we have 30,000 square feet and we probably had less than 5,000 square feet before. One very pleasant addition has been the recreational reading room where non-medical material is to be found, and here we have plays, novels, biographies, travels, and sports books. It's a small collection which I hope will grow by gifts.

Q. Are there any other particularly interesting features of the new library?

A. Yes, I think the group study rooms are very, very attractive. They are on the North periphery of the 13th floor and of the 11th floor and these vary as to size, seating four people, twenty people, and each one of them has a black board in it and the Library Committee has established a policy as to the use of these rooms. They are for group study, and also can be scheduled for journal club meetings.

Q. Would you say that our medical library compares favorably with other such facilities around the country?

A. Physically, I would say it has a very favorable comparison. The collection itself is just a medium sized library. We have hopes for expansion, but that will require . . . will depend on the support given the Library.

Q. Have you ever despaired over the years of getting adequate space for your Library?

A. Oh, no; you know, you work just one day at a time, but we really had arrived . . . we were at the point of no return, that's all. There simply wasn't any other space. We were hanging journals on doors by means of the peg-board and a little steel holder that would display it. No, I'm not a despairing sort of person. But I do think it's nothing short of a miracle that we have it, and then it happened so quickly, and this of course, as far as I can perceive is the work of Dr. Ebaugh. This whole building and then this thought that he had of adding the Library to the building. I think this community is greatly blessed to have had this man in our midst.

Conan Kornetsky, Ph.D.
Research Professor of Psychiatry and Pharmacology,
Boston University School of Medicine

Q. Dr. Kornetsky, research is one of the hallmarks of a major medical center. How would you assess the research being conducted here?

A. Research here at the Medical Center is very broad; it covers many areas and has grown tremendously in the ten years that I have been here. Ten years ago when I came to the Medical Center there were very few people doing research . . . the amount of grant money was quite small, facilities were quite poor . . . we did not have our present research building . . . The Housman Research Center; we did not have our Instructional Building. I think the evidence of the amount of research that's going on can be seen not only in the buildings, but the number of people here in research and the dollar amount of research that's going on. We've now succeeded in attracting scientists and clinical researchers from all over the country. I think we don't have to take a back seat to any medical center in the country.

Q. What are some of the major areas of research here in your lab?
A. Well, in my laboratory there are two major areas of research . . . one is involved in trying to understand schizophrenia . . . we're quite interested in this disease and we're trying to understand it from a somewhat organic point of view. We do two types of experiments in our laboratory in our attempt to understand this disease: one involves work with drugs with patients at Boston State Hospital where we have a laboratory, and then here in our laboratory at the Medical Center a lot of our work is involved with brain function in animals.

The other area of research has been in the area of physical dependence and tolerance to opium-type drugs. We have been quite interested in the problem of tolerance to drugs . . . we have been investigating various phenomena of tolerance. For example, one of the things that we have found in the past few years is that a single dose of morphine will influence a second dose given as long as a number of weeks after the first dose. This single dose tolerance may not have direct relevance for people at the present time, but it may help us understand the whole phenomenon of tolerance. And tolerance to opiate drugs is . . . besides having intrinsic interest to a scientist . . . a medical problem. One of the problems in handling clinical patients with problems of pain is the fact that they become tolerant to most of the drugs used in controlling pain. Now if we can understand tolerance maybe we can do something so that we can give more relief to more patients who are in pain.

Q. In the past decade, federal and foundation funds have extensively supported medical and basic science research. Do you feel that the expenditure has been fruitful and worth the investment? Would you like to see an increase in the level of government support?

A. I would certainly like to see an increase in the level. One of the problems right now is that government support for medical research has leveled off, due to increased cost over the years, this is in effect a decrease in support. Many people who have applied for government grants at the present time find that the grants are approved and not funded because there is no federal money.

This federal money that has been spent in the last 20-25 years has certainly, I think, paid off. I can talk more specifically about the area of mental illness, where a lot of work supported by the National Institutes of Mental Health has paid off in the treatment of the mentally ill. At the present time there are fewer people in mental hospitals than there were 15 years ago. In fact every year the number of patients in public mental hospitals has decreased despite the fact that the population has been increasing. We can attribute this greatly to the use of new drugs, and the research on many of these drugs has been supported by the federal government in their research programs. We've come a long way in understanding a little bit about how the brain works but we have a long way to go . . . and only through further support can we really understand this.

Q. Lately increasing attention is being given to pressing problems in the delivery of health care. How do you view possible cutbacks in research support for a diversion of funds for delivery of health care to the underprivileged?

A. I think this would be a short range view. The immediate effect might be some immediate improvement which we certainly need, but in the long run I think it would be detrimental to the American people. You find that basic research is often ahead of clinical application by a number of years, and clinical application feeds off of basic research. If this basic feed is used up there will be nothing for the clinical research to feed off of after a while and progress will stop.

We have to train more people in medical sciences and we have to . . . in order to train these people . . . we have to have funds . . . we have to have funds for them to go on and do research that will contribute to the general good. I think that if you compare the amount of money we spend in medical research against things like the amount of money we spend in this country for tobacco, the amount of money we spend for military endeavors . . . you'll find that our total expenditure for medical research is very, very small.
Q. Sabra, how do you feel about University Hospital after nine years on the staff?
A. I'm happy here. The job is very interesting... it has become more so in the last two and a half years... and has many good programs going... enlarging personnel functions and responsibilities. The hospital is a place where you feel you belong.

Q. Is it because of the hospital's size or do you think there's something special?
A. The people... I think the size has a lot to do with it... and the people, and the goals in the hospital. We're making progress now... we were at a standstill I think... and I think that perhaps this was a time when a lot of plans were being made, but now there is a lot of progress.

Q. A former Hospital patient reported that she felt a spirit at every level among Hospital people, among the housekeeping staff, nurses, house staff and physicians. Do you feel this in the Hospital?
A. People have said who worked here that it is a friendly place, and people I've interviewed have said they've heard from others that it's friendly. You get to know people and they don't just pass you in the hall, but they say good morning or hello. There's a feeling here that someone up there likes you.

Q. Hospital costs seem to be the subject of continued discussion. What do you see as the single most significant factor
causing the increase in hospital costs that we've been experiencing?

A. The biggest factor is, of course, inflation. In addition to this, we continue to have demands for additions to clinical services, which develop from the research that is done in hospitals; when the research is finished then they become standard hospital services. An example of this would be the dialysis unit which for several years here was run as a research unit and has been recently put on a service basis. In addition to this, of course, we have the needed adjustment for salaries; 70% of our hospital cost is payroll so whenever we adjust salaries we affect the cost drastically.

Q. How do our hospital salaries, excluding the medical profession, compare with those paid by industry?

A. Well, as you know, we were one of the first hospitals in Boston to do a complete wage and salary survey using the industrial system which has been adopted by many of the local industries in Boston and throughout the country. This was completed in August of '67 and since that time our salary scales have been based on the industrial market and adjusted where necessary to meet the hospital competition. Our salaries are competitive, and we must stay in this position if we want to continue to attract and keep good employees.

Q. What would you say is the single most significant problem that you face in the daily operation of the hospital?

A. In addition to trying to do something about continued rising costs, I think the biggest need of the hospital is space, the need for additional beds to provide more service and the need for additional space to provide the adequate back-up support services which are required. The problem we have is that we are occupying a very old facility and we have limited services which can only be solved by additional construction and remodeling.

Q. Has the shortage of nurses had an effect on the level of our patient care here at University Hospital where there has been a long tradition of excellent care?

A. I've been in hospital administration for 20 years and I've heard nothing but shortage of nurses for that length of time. I think we have done much in this hospital for the last two years to try to develop good personnel policies and salary ranges to attract nurses . . . trying to plan for the use of clinical specialists which is a new concept in the care of patients.

I feel that we want to take a good hard look at our present nursing service structure to determine whether in the years ahead we want to continue providing care on the same basis as we are now doing, or whether there are other ways in which some of the administrative service areas can be handled by other personnel. 50 percent of our current staff are nurses who hold B.Sc. degree or higher. This indicates that the quality of nurses which we are employing is quite unusual, and should contribute to making our nursing care of the highest standards. As far as the shortage of nurses is concerned, this year we are much better off at the moment than we were a year ago in terms of numbers of nurses, and I feel that we are holding our own very well this year and probably doing as well as many hospitals in the Boston area. A shortage in nursing has existed since the second world war but during this time we have added many new duties . . . many new responsibilities for nurses. Then, there are many opportunities outside of the hospital for nurses which did not exist at that time, and we are doing more complicated types of surgery at this time, because of improved anesthesia and new techniques which require more manpower to care for patients. Acute care units, cardiac care units have arisen and been developed at this hospital and other hospitals in an effort to keep up with the demands for good nursing care. Somehow, during this period of time patients have received care and when we refer to shortage of nurses, I think we are talking about a relative figure and I don't believe many of us will ever assume the ideal situation for some time. Hospitals have expanded with Hill-Burton construction during this period so that we have increased the number of beds and facilities in the United States but we have not, at the same time, trained nurses or paramedical personnel to meet the needs of the hospitals.
Q. As a community leader involved with several major Boston hospitals, how do you view the particular contribution of University Hospital?

A. Every institution is unique, and brings to its task a style, a tradition, and a sense of its role that distinguishes it from similar institutions. University Hospital has an enviable tradition of service to the community, a dedicated group of staff members and employees, and a corps of supporters who have chosen to identify themselves with the Hospital’s goals and problems. Today’s critical shortage in health services makes the Hospital’s contributions of maximal significance. From its provision of direct medical care to the community, through its major involvement as a teaching center, to its fostering of a wide range of research projects, the Hospital plays a vital role in the total picture of New England medicine.

Q. Major changes have been taking place at the Medical Center during the past few years and more are projected during the next half-decade. What expansion is planned at University Hospital?

A. An integrated and carefully conceived master plan for the Center’s development has been moving toward completion in dramatic fashion. At University Hospital, the new home for the Evans Department of Clinical Research is presently under construction, with plans in the final stages for the construction of the Health Services Building. The Hospital’s trustees have given probing attention to the Hospital’s growth pattern and potential, and its relationship to the expanding Medical Center. The addition of 85 beds in the new Evans building, and the renovation of the present Evans building for the Division of Surgery will, with the full utilization of the Medicenter for non-acute patients, virtually double the hospital’s present bed capacity.

Q. What directions in programs do you expect the Hospital to take in its growth during the next decade?

A. One important role that University Hospital is increasingly assuming is that of medical leadership in a regional sense. Our cancer unit was recently selected to operate the first Regional Medical Care Program in the field of cancer to be established in the tri-state area of Massachusetts, New Hampshire, and Rhode Island. Our Department of Surgery has been active for some time now working with our affiliated institutions, particularly those south of us, in coordinating training programs, making maximal use of costly equipment, and seeking to make the expertise in our Department available to a number of community hospitals. While a formal regional medical program has not yet been approved for this area, I would anticipate that University Hospital would continue its development of similar individual programs of this nature to increase its regional effectiveness.
Q. Dr. Rohrbaugh, what do you feel are some of the highlights of the Center's development since its formation in 1962?

A. We've made great strides in many directions. Some of our greatest assets are our human resources—the vivid, alert, and able personalities we've recruited not only among our faculty, and at the staff level, but among our trustees as well. Another area of great change has been our financial picture. We began in 1965 with a ten-year development program totalling 62 million; it has now grown for that same period to almost 75 million. At the end of this calendar year we will have seen new brick and mortar around us representing almost 42 or 43 million either completed or under construction.

The launching of our Six-Year Program in the School of Medicine was a great milestone for us, and the expansion this past year of the entering class by 33% was another. A signal development has been the reorganization and the revitalization of the Ph.D. graduate program in Medical Sciences—a part of the graduate school—which has expanded at a greater rate than the medical school itself. Still another development was the beginning of the new School of Graduate Dentistry in 1963—a first in the country—which has set new records in every direction, particularly in the area of post-graduate education with workshops which draw outstanding practicing dentists and teachers from all over the world.

At University Hospital we have made great progress not only with the building construction, but the development of a great many new and vibrant programs like those in academic medicine and surgery. The development over these last seven years of our affiliates has been a single success—particularly in this last year the development of the integrated residency and internship program in surgery at Brockton, Malden and Carney. The Medical Center which we initially had to explain in terms of its meaning and its location to most people, has gone far beyond that point and I think it's recognized locally and regionally and nationally for its accomplishments. This doesn't mean that we haven't had and we won't continue to have a great many frustrations, but as we begin further to explore the role of a university medical center in a community setting—a local community, a regional community, a national community—I agree that we will be able to, let's say three years from now, to serve as a pretty good model of what a university medical center can accomplish and should accomplish in terms of education, research, patient care and community relations.

Q. What are some of the problems that you see facing us in the years to come?

A. Well, I mentioned the root of all evil, money. I believe that the greatest problem will be the funding, particularly of medical education. I don't see the funding of medical care as being too great a problem with the development of
third party arrangements, particularly Medicare and Medicaid, but in terms of the university medical center serving as a producer of health manpower, not only of medical students, but dentists, nurses and other paramedical personnel. This I see as a major problem because we can’t finance that kind of manpower development from tuition alone, and the only way we can look to finance it is from continued private help, but much more, state and particularly federal institutional grants.

Q. What do you think that we might see at the Medical Center 10 years from today?

A. Well, if all goes as anticipated, let’s see, by 1979 I would think that first of all, you would see in terms of plant probably, on our own grounds, a nursing home plus all of the other ancillary resources we don’t now have: housing for our staff, our students, our faculty, and places for them to meet such as a student union. Interns of ten years from now would expect a plant which would have about everything that was needed in a university medical center, probably all, in a sense, under one roof because it will have all been connected. More than that, however, I would expect to see a high rise hospital and some new efforts well under way in terms of stroke centers, in terms of bio-medical engineering and in terms of a lot of other developments which in many cases we are now just on the fringe of. I see us having studied and either abandoned or kept and enriched our whole health delivery system under which we are perhaps one of the few remaining university medical centers to practice medicine the way 90% of medicine in the United States is practiced... on a private basis... but with our having worked out an effective way to plug in patients through the whole system.
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United States Public Health Service Hospital
(Brighton Marine
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As of December 31, 1969
Boston University Medical Center
Financial Statement*
1968-1969

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* B.U. Fiscal Year 7/1/68-6/30/69. U.H. Fiscal Year 10/1/68-9/30/69
** Medical Center Administration Expenses paid in F.Y. - 69
*** Excludes B.U. Support of 50% of Medical Center Administration expenses
**** Transferred to General Fund Unrestricted Bequests to restore amounts used to meet operating deficits of prior years.

March 11, 1970