Academic activity during the 1975-76 year concerned the evaluation of our educational programs, a review of our relationships with our affiliated hospitals, further efforts to expand our research, and a serious attempt to contain the expanding cost of our operations. In part, these activities were brought about by the report of the accreditation visit by the Liaison Committee on Medical Education in the Fall of 1974. A progress report on some of these matters was submitted to the LCME in July 1976.

This report responded to eight concerns which had been expressed in the original accreditation survey. The first dealt with the relationship of the teaching units at Jefferson to the corresponding units in our affiliated hospitals. In response, the report indicated that Jefferson has increased the number of hospitals which participate in the clinical education of our students, as have most medical schools, in order to accommodate increased enrollment. It was emphasized, however, that the standardization of our medical education programs in these various hospitals has been a continuous concern of the faculty.

The Committee on Affiliations has established procedures for integrating and evaluating all of the clinical teaching programs. A concise guideline has been developed to assist the clinical departments to achieve a closer integration of these programs. The committee also has developed an evaluation form whereby each medical student can report his experience on clerkship programs at all hospitals.

Since the best test of a clerkship experience is the measurement of the performance of students who have taken that clerkship, the Office of Medical Education at Jefferson began a study in 1974 to develop a model for the evaluation of the clerkship programs at Thomas Jefferson University Hospital and also at our affiliated hospitals. This study was described in the Fall, 1975 Alumni Bulletin.

Secondly, the visitors indicated a good deal of satisfaction with the development of our new curriculum, but they expressed some worry about the effectiveness of the two new interdepartmental courses entitled "Approach to the Patient" and "Medicine and Society." These courses are given during the first two years of the curriculum and are intended only to expand the students' knowledge of clinical material and not to develop their skills in physical diagnosis. A careful assessment is made of the clinical knowledge of the second-year students before they are advanced to the clerkship programs of the third year, and these results do not confirm the conclusion of the visitors. In addition, the Minitest of the National Board of Medical Examiners is administered each year to all students at the end of the second year. This examination contains 180 objective-items previously used and tested in the Part I (Basic Science) examinations of the Board and a similar number of items taken from previous Part II (Clinical Science) examinations. The results of these examinations have been evaluated each year, and these evaluations demonstrate that about 90% of the second-year class at Jefferson could be expected to pass the Part II examinations of the National Board if they were written during Jefferson's second year instead of the fourth year as usual. Such data year after year demonstrate that the Jefferson sophomore student is exceedingly well prepared from the knowledge standpoint to enter the third-year clinical program.

Thirdly, the visitors expressed concern about the Department of Psychiatry, and indicated that certain program weaknesses in this department had ramifications for the entire educational program in the area of the emotional component of illness. It was pointed out that the Jefferson medical faculty is one of the few in the country which has established a procedure of periodic departmental review. These problems had been reported by the Committee on Departmental Review before the surveyors ar-
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The Jefferson baccalaureate nursing student is exposed to a wide variety of clinical situations in the two-year program. Pennsylvania Hospital's Labor and Delivery area, where a student reassures a patient tested by a fetal monitoring device, is one such rotation.
Nursing Education In Transition

Now in its fourth year, TJU's B.S. program has a different approach to teaching students in a changing profession.

by Joy Roff Mara
While health care professionals nationally demonstrate little consensus and less harmony regarding the future of nursing, one fact is beyond dispute: the profession, its expectations and sense of identity, are changing. The change has been far from precipitous and even the most enthusiastic must admit it is far from accomplished. In their desire to escape what has been termed "the bedpan mentality," nurses who want to see their profession upgraded and accepted as an independent entity in its own right are emphasizing education, particularly in academic institutions.

Although three-quarters of all the RNs employed in this country today are hospital-based, three-year, diploma program graduates, the number of these programs is declining. The decline has occurred in part because the advent of third party payments, and the attendant sensibility that patients should not bear the costs of health education, has made it difficult for hospitals to continue their financial support.

Perhaps more important, however, have been the changing educational emphases within the nursing profession itself. While the American Nurses Association, for instance, does not deny the very real and very admirable contributions diploma programs have made and continue to make, in 1965 it created a furor within its own ranks by recommending the baccalaureate degree as the basic professional nursing preparation. In 1977 nurses are involved in state legislative campaigns in such states as New York, Idaho and Ohio to raise the entry-level minimum standards for registered nurses to include the B.S. degree. In New York specifically, a coalition of all nursing groups, including diploma graduates, are demanding the degree be required of all those who take the nursing board examinations by 1980. Those without degrees would take another examination altogether and qualify as nursing associates.

Although there are grandfather clauses in most of these proposals, the trend they imply is understandably frightening to some of those within the profession whose careers have been based on the traditional assumptions about the nurse's role. It is also frightening to some of those without. Joyce Ann Elmore, Director of the American Nurses Association, Department of Nursing Education, suggested in a recent interview that many physicians and hospitals oppose such developments because better educated nurses are likely to become more independent and aggressive and less inclined to accept routine hospital chores as their primary function. Because most baccalaureate programs have less emphasis on technical clinical skills than diploma programs, students spend much less time on the hospital floors. This obviously denies hospitals part of their traditional work force, what some are now terming their student "slave labor."

A recent confrontation at the University of Texas, where the Nursing School lost its centralized office and with it much previously enjoyed autonomy in curricular and budgetary matters, reflects this aspect of the national conflict in microcosm. While the nurses feel the decision was part of an attempt to deny their independence and keep them under physician domination, the physicians and administrators insist that the bachelor's programs were not producing "well-qualified" nurses in a technical sense. As one Texas physician commented, "Some of the basics were being ignored. You've got nursing students coming out (of B.S. programs) who don't know how to change the sheets."

Jefferson is somewhat unique among institutions of nursing education, in that it offers three different preparatory options to nursing students. It has offered since 1891 a well-respected diploma program. About 15 years ago programs to train licensed practical nurses came into vogue, and Jefferson began its L.P.N. course in 1961. Although degree programs have existed since the 1920s, their national acceptance was not immediate. September, 1972 brought the first class of baccalaureate nursing students to the TJU campus. While each program has its own director, administratively all three come under the aegis of the College of Allied Health Sciences.

Although assignment of specific functions and duties even within the nursing ranks is changing, the goals of the vocational L.P.N. program are perhaps the easiest to differentiate. The approximately 65 students in the Jefferson class follow a 12-month curriculum that includes 15 weeks of classroom instruction and 34 of clinical training. While they are given a background in body structure and function, pharmacology, nutrition and maternal/child health nursing, the program emphasis is on medical/surgical nursing.

The L.P.N. is trained to be part of a health care team, working usually under the direction of an R.N. While there is no uniform standard from hospital to hospital, at Jefferson the practical nurse is expected to perform non-technical bedside care. L.P.N.s here are not permitted as a general rule to give medication; neither is the dispensing of drugs a part of the Jefferson curriculum. The forte of the practical nurse today, and what the School's Director Elizabeth Sweeney sees as its most sanguine future direction, lies in the care of the chronically ill, in rehabilitation medicine, extended care facilities or home health care.

One of the two professional educational alternatives at Jefferson is the diploma program, a 33-month course which emphasizes the preparation of a generalist capable of assuming beginning positions in hospitals, extended care and health maintenance facilities. This is accomplished through a strong science-based curriculum and nursing courses developed from a conceptual framework of basic needs and health care needs. These courses are organized in levels of progression from simple to complex. Focus is on the process of nursing in a variety of settings and the student is given directed experience toward assisting man in those activities which are required for him to attain, maintain or restore his maximum health potential. Theoretical and clinical learning experiences are provided in Medical-Surgical, Community Health, Psychiatric and Maternal-Child Health Nursing, including health maintenance, acute, chronic, emergency and critical care. According to students and administrators, the program is a demanding one with three days of clinical practice and two days of class each week for upperclassmen.

The program which has been pre-
When 31-year-old Nancy Redner decided she wanted to be a nurse, she faced more obstacles than the average prospective practical nursing student. First she had to complete the high school education that had not seemed important to her at age 16. Second, she had to develop study habits and an academic orientation, something not easy for anyone who has been away from school for 15 years. Last, and perhaps most important, she had to get the support of her husband and three young children and learn to fit education into an already established family life.

Finishing her high school degree proved to be easier than Mrs. Redner had expected: she passed the exam after three months of study at Northeast High. A friend convinced her that the Jefferson practical nursing program was the closest to what she wanted, and she feels after several months of classes that her expectations are being met. The academic course, so far including the nine systems of the body in anatomy, nutrition and diet therapy, and emotional and family problems, presents enough of a challenge to require four hours of study per night of Mrs. Redner. Although the clinical portion of the course had not begun as of this writing the students are preparing for it in their laboratory sections by practicing some of the simple procedures like changing beds and giving baths.

While class members are primarily recent high school grads, most ages are represented and many backgrounds, including some college. Several, like Nancy Redner, had been nurse's aides or assistants who found their lack of nursing education limiting and wanted to assume more responsibility. Despite the differences, the class is friendly and close, "a pretty jolly bunch," says Mrs. Redner.

The impetus to become a practical nurse was in part pragmatic for Mrs. Redner; her husband is a construction worker who faces frequent lay-offs. He completely supports her choice, and when he is out of work takes nearly full charge of the house and the children, ages 13, 11, and three, to leave her time free for study. Neighbors help out watching the children when her husband is employed.

After graduation Mrs. Redner plans to get some hospital experience and then to work in an extended care facility as she did while a nurse's aide. This setting appeals to her because the nature of the long term care patient's problems usually allows the practical nurse to be substantially in charge. She has also considered the possibility of taking a hospital advanced course in pharmacology to be prepared to become involved in giving medications, and keeps the idea of one day obtaining an R.N. in the back of her mind. At this point, however, the duties of a practical nurse appeal more to Nancy Redner than those of any other nurse. "I like bedside nursing," she says. "I learned as a nurse's aide how much people appreciate it when you make them comfortable and communicate with them while you attend to their basic needs. You can establish a satisfying human contact on a fundamental level."

Nancy Redner, L.P.N. Student
The Satisfaction of Caring for Basic Needs
viously described in the *JAB* has been extraordinarily successful in producing quality graduates because it has kept pace with the times, making curriculum and policy revisions in keeping with changes in education, nursing and nursing education. To date, nearly 5000 nurses have been graduated and current enrollment includes 300 students, nine of whom are men. According to Doris E. Bowman, Director of the school, the school graduates have never had difficulty in obtaining positions; in fact, they have been sought after.

The differences between Jefferson's two professional nurse education programs, the diploma and the baccalaureate, are at once obvious and subtle. As one respondent put it, "What do you mean, what are the differences? With one you get a college degree and with the other you don't." That perspective is of course simplistic, but it is interesting to note that while the diploma course takes nearly three years to complete, it entitles its graduates only to 11 college credits. This has presented a considerable hardship for R.N.s who decide to continue their education, and at Jefferson administrators are working to devise an appropriate way to offer some kind of advanced standing by 1978 to diploma graduates entering the B.S. program. In attempting to equate and relate pertinent parts of the two programs, however, their more subtle differences are not always easy to reconcile.

While labored exegesis of both schools' stated philosophies and objectives would be inappropriate, a simple comparison reveals many broad similarities: the encouragement of responsibility and growth, provision of optimal patient care, the concept of the nurse as health educator, awareness of the sociologic and behavioral implications of health care, etc.

Jefferson's newest program, however, has an additional set of unique goals, whose implications for the baccalaureate curriculum have been considerable. One such goal is preparing students to be leaders and to function effectively as agents of change during the profession's period of transition. With reference to humanistic values and the worth and dignity of each individual, stimulating personal and professional growth is stressed. The expectation that the B.S. graduates will continue their education is made explicit, and instilling an appreciation of the levels of knowledge and practice in nursing as well as its various tools is a thirdestated purpose. Department Chairman Dr. Charlotte Voss stresses that, "We are preparing our students to function in a wide variety of environments, not solely or even primarily in a hospital clinical situation. We want our graduates to have an understanding of health and the problems of health care so they can help others understand."

The program emphasizes that a knowledge of the humanities, various forms of creative expression and the social/behavioral sciences is necessary to the understanding of nursing theory. Since Jefferson does not offer such courses, the B.S. program is a two-year one with students completing their first two years elsewhere and transferring here for the junior and senior terms.

Admissions standards are quite high with the average grade-point average of this year's entering juniors a 3.25 on a 4 point scale and the average combined S.A.T.s about 1100. Of its 66 members, four are male, four are black, and 14 are non-Pennsylvanians. While the greatest number of students (10) came from Temple University, schools like George Washington University, the Universities of Miami, North Carolina, Massachusetts and Vermont, Skidmore and Case Western Reserve all are represented. Because a concentrated science background is neither required nor desired, each class is remarkably heterogenous, varying in both educational background and age. Thirty-nine percent of the junior class, for instance, is over 23, and many students have already completed bachelor's degrees and/or worked independently in various fields. Because discussion and inquiry are encouraged, the diversity of backgrounds is seen as a plus by faculty and students alike.

With the exception of human anatomy and physiology, microbiology and biochemistry, the course is not organized around the traditional medical specialties. It is an integrated curriculum based, like many B.S. nursing programs, on psychologist Abraham Maslow's hierarchy of physical and psychological needs. These include, for example, the needs for safety, physiological well-being, love and belonging, esteem and self-actualization. The nurse's role in man's normal need satisfaction, which is related to health maintenance, and in interruptions in need satisfaction, like illness, are both followed sequentially from the fetus to old age and death. Courses in psychology, sociology and statistics are also included.

The grading system is a modification of a normal curve, revolving at present around median performance, because faculty do not feel their predominantly multiple choice test items are as yet sufficiently refined to follow a strict percentile form. In cooperation with the Office of Medical Education the Department is currently developing an item bank for computer verification which will probably change the system in the future. There are mid-term and final examinations in most courses, and these are geared as much as possible to the nursing boards.

Students are graded separately in the academic and clinical areas, with the latter done on a pass/fail basis. Clinical grades are based on how well a student meets the objectives prescribed for each area. As one student put it, however, "It is our understanding and application of theory that are evaluated. No one is ever graded on how well he or she gives a sitz bath." While the failure rate is not high the course is unanimously conceded to be a difficult one, especially in the first year. A's are uncommon, which is culture shock for many students who've maintained averages of 3.25 and up in the first two years of college. Competition for grades is not stressed, however, and the atmosphere is anything but cutthroat.

The clinical laboratory portion of the curriculum is closely integrated with the academic and follows the same general pattern. Considerable clinical experience is taken away from the Jefferson complex at a wide variety of institutions from public health and health maintenance clinics, with the opportunity to observe ambulatory care, to hospital situations at Methodist, Children's, Penn-
sylvania and TJU Hospitals, to nursing homes and extended care facilities. The last quarter of the program is a nursing elective, with six to eight usual possibilities from which to choose. However, faculty members are more than willing to adapt the program as much as is feasible to the individual's interests.

Senior student Susan Loughery notes that learning technical skills is secondary. "Our main goal," she says, "is learning to help a patient care for himself, involving him in planning his care and helping him adjust to his situation." As part of this effort, students may teach prenatal classes in clinics or in homes. Some follow an expectant mother through pregnancy, delivery and the postpartum period, acting as advisor, friend and teacher. The first clinical experiences are in the nursing homes, to help students learn to interact with older people and adjust to their roles in a low-key, relatively comfortable situation. "We try to teach beginning skills, and our emphasis in all the clinical laboratories is on communication as well as technical competence," notes Dr. Voss.

The pattern in most clinical situations is similar. Students are assigned one or two patients who become "theirs" for the approximately 10 weeks of the rotation. They are expected to read the charts, looking up any unfamiliar terms or regimens, and to work up drug cards with the nursing implications for their patients. Faculty members are present to demonstrate techniques and answer questions, but individual initiative and responsibility are expected. On rotation at Pennsylvania Hospital's newborn nursery, for instance, each student after one demonstration provides his or her infant patients with basic care, including feeding, bathing, instructing the mother in breast-feeding, etc. They also watch their charges for indications of potential or actual problems. Students on all rotations are also expected to evaluate their performance with regard to the stated objectives in each area; this, according to both students and faculty, is one of the most important aspects of the program.

The typical criticism of B.S. programs nationwide is their seeming failure to produce technically skilled practitioners, and Dr. Voss and her students do not deny that most baccalaureate nurses need a period of on-the-job orientation to become thoroughly adept in skills. "But how many other professions," asks Dr. Voss, "expect recent college graduates to perform like experienced staff members during their first few months of employment? Making on-the-job experience the basis and primary activity of an educational program is exploiting the student." And senior student Ray Furlong notes that because the B.S. program does provide a summer vacation he and most of his peers have the opportunity to sharpen their skills through summer and part-time work. He spent last summer working in an intensive care unit and feels it was a useful and suitable way to become more comfortable with the clinical setting and its technical requirements. Allied Health Dean Marten M. Kernis states that maintaining the level of technical competence of baccalaureate students as well as investigating new and unique methods of education will be his priorities for the program in future years.

One of the most important facets of the baccalaureate program is student research. Projects are completed by groups of five or six, and involve studying the medical resources of a community, evaluating them and in some instances offering solutions. One group last year, for example, disseminated birth control information in a town in New Jersey after their study had revealed a community deficiency in this aspect of health care. Another project concluded that a New Jersey community lacked adequate personnel for its rescue squad and set about advertising the fact in town to interest more volunteers. One community is now hoping to publish the results of a student review of its health resources, to inform its citizens about all the facilities and programs available to them.

In addition to doing their own research, students are also encouraged to be educated consumers of others' research results, to regard "the literature" critically and have the background to review its methods and techniques knowledgeably. Faculty research is also emphasized, and members report that student response is encouragingly skeptical. "In one case where our study was in the preliminary stages," an Associate Professor notes, "the students were almost embarrassingly sharp. Their first question was 'Has your tool been tested?' and that of course was one of the things that remained to be done."

The B.S. program's formal statement of goals and purpose talks about encouraging leadership skills needed for the nurse to function as an agent of change. It emphasizes the development of personal qualities and in this regard describes the nurse the department hopes to produce as a liberaly-educated, independent, decisive activist. Instilling values and shaping attitudes is obviously more difficult and complex than teaching skills or facts. For this reason, Nursing in Society, the primary curricular vehicle for stressing these concerns, is one of the most interesting facets of the program. Using the debate format, issues and trends in nursing today are discussed, and students are encouraged to question and express opinions freely. While the course would appear to have distinct overtones of consciousness-raising, the ideals of the program are not preached or litanized.

Students and faculty agree that however subtly the program's personal goals are conveyed, the majority of students do adopt them as their own. Experience with role models is one important influence and the faculty themselves display many of the promoted characteristics. At least a master's degree is required of all 12 full-time and part-time instructors, representing all faculty ranks. The emphasis on scholarly research, for example, is expected to increase further under the direction of the new Allied Health Dean, Dr. Marten Kernis. Many of the nursing professors are professionally active outside the University, with one member Treasurer of the local Pennsylvania nurse's association, and others involved in the district and national organizations.

Department Chairman Charlotte Voss is perhaps the best role model of all. Like a number of the faculty she began her career as a diploma nurse, but went on to continue her education. Eventually she received her Ed.D. from the University of Pennsylvania in 1957.
There has been a fair amount of discussion, in this publication and others, of
the problems faced by women in the once traditionally male physician's role.
Less marked but potentially as discomfiting are the situations encountered
by men who become nurses. Joe Cammoroto, a junior in Jefferson's diploma
nursing program, feels far from constrained by his non-traditional role, but
notes that the University as a whole has not been altogether able to renounce
sexual stereotypes.

Admission to fraternity parties, for example, has always been free for the
nursing students, but now the men are charged. Being treated differently can
also work to their advantage, however. The unmarried women diploma stu-
dents are required to live in the Martin residence and abide by its regulations.
The males can live where they choose.

(As of next September this ruling will no longer apply to the distaff diploma
nursing students.)

Mr. Cammoroto, who spent two years
at Philadelphia College of Pharmacy
prior to beginning the diploma course,
finds that other nurses have no difficulty
accepting male colleagues. "It is the
male medical students," he says, "who
have trouble understanding why I didn't
want to become an M.D."

His reasons are clear and well-thought
out. "Nursing isn't bedpans," he com-
ments. "It's people. A nurse and a physi-
cian contribute different skills toward the
same goal and get different rewards. I find
the greatest satisfaction comes from helping
the patient on a personal level, and
nursing provides more of this interaction
than medicine does."

While he was a pharmacy student,
Mr. Cammoroto worked at Jefferson as
a nursing assistant, which convinced
him both to enter the nursing profession
and to do so through a diploma pro-
gram. "I wanted to develop my floor
skills, and from my observation of Jeff-
ferson, this course seemed to be the best
way." He does not feel the program is
academically overpowering, but sug-
gests that his two years of college were
excellent background and help make it
somewhat easier for him. Clinically, he
is now giving total patient care, giving
I.V.s and medications fairly routinely.

His diploma training does not indi-
cate a lack of academic desire, however.
He hopes to specialize in cardiopulmo-
nary nursing and says, "I know the B.S.
is necessary and I plan to go for my de-
gree on a part-time basis while I am
working after graduation. In fact, I
hope eventually to go on for my mas-
ter's degree."
Statistics reveal the heterogeneity of the baccalaureate nursing students, but the experience is better conveyed in the casual statements of its class members. "I heard about the Jefferson program through one of its senior students," says current senior Barbara Hordis. "She worked after high school with my daughter."

When Barbara Hordis decided to get her college degree she was 43 years old, her five children were grown, and she had not worked in more than 20 years. After going through two years of liberal arts at Montgomery County Community College with relative ease, she was surprised at how demanding Jefferson's baccalaureate program proved to be. Two of her children are also in college, however, and the unusual peer pressure works to everyone's advantage. "The kids are always questioning me about my performance," Mrs. Hordis says, "especially after exams. On more than one occasion they've told me, 'We're sorry, Mom, but this isn't good enough. You can't go out tonight.'"

One of the aspects of the program which she finds most interesting is the group project, often involving presentations to or informal discussions with hospital or clinic patients. At first the groups are self-formed, but as the course progresses they are randomly assigned. "The rationale," she explains, "is that so much of nursing is learning to cooperate as part of a team. And in the working situation the team is much more likely to consist of strangers than friends."

Mrs. Hordis finds her fellow students to be a very mature group, whatever the age, and notes that everyone usually does his or her part to make the group ventures go smoothly.

Mrs. Hordis had one liberal arts course requirement still to fulfill when she began the Jefferson program, which she completed during her summer vacation. This unfortunately left her no time to get some hospital work experience, in which she still feels deficient. "There is so much to learn and so few hours," she says. "I feel I understand the theory, but I need more experience to feel confident in my performance." For B.S. nurses who want that extra practice in skills and hospital routine, several hospitals such as Temple offer an intern program to the new graduate. Before pursuing her ultimate interest in medical-surgical nursing, Mrs. Hordis hopes to take advantage of such a program, where she can be paid a normal salary to rotate through the different hospital units, gain confidence and decide what situation is best for her. Proliferation of this type of experience could make the student-to-staff transition less of a jolt for baccalaureate grads, and could also help refute the standard criticism that the B.S. nurse is not technically adept.

While the usual image pictures the student living sparsely amidst dorm plastic or Good Will-iana, Mrs. Hordis has responsibility for maintaining two homes, one in Huntington Valley and one in Ocean City. She is not certain in which area she will choose to work after graduation, but she does feel confident that the B.S. degree will further increase options for satisfying work that five years ago did not exist at all. "This is a good program, but it is especially good for family women," she notes. "Even if you've taken your liberal arts courses ten years ago, there's still a place for you."
She has been involved in nursing education at several levels, including establishing associate and bachelor's programs at Northeastern University in Boston and the associate degree program at Harrisburg Area Community College. At these institutions she became Dean of Nursing and Director of Nursing respectively. Dr. Voss was central to the design of Jefferson's B.S. curriculum and as Chairman of the Department of Nursing continues to direct its evolution. She is also active in the National League for Nursing, the accrediting agent of the profession.

Inter-faculty and faculty-administration relationships seem in themselves to be something of a model and set a tone very much in keeping with the objectives of the program. The predominantly young faculty describes itself as cohesive and, because of the cooperation needed to teach the integrated curriculum, would be in a poor position to inculcate the Department's values and goals were it a collection of squabbling prima donnas. There is mutual respect among them and between the faculty and Dr. Voss. Assistant Professor Jane Edwards, for example, notes that Dr. Voss encourages the same independence in faculty members that professors do in students. "Dr. Voss makes it clear that she trusts us. She characteristically allows people to be all they can be and do all they can do."

The openness and availability of the faculty to the students provides another positive reinforcement. The school is small enough and the faculty/student ratio manageable enough to allow personal relationships to develop. Faculty members report that a good portion of their time is devoted to personal counseling. Senior Susan Loughery couldn't have been more positive about the Department's concern. "They're always there, faculty or administration. You can talk with them honestly, and they'll try to help. If you're having a grade problem, for instance, they'll make sure you get a tutor." And the good feelings are once again mutual. The faculty reportedly enjoys teaching the B.S. students because they are bright, interested and interesting.

Another reinforcement is the notable lack of restrictions regarding students' non-academic lives. No one is required to live on campus, although some do choose to live in the Martin Residence. Unlike the diploma women, B.S. students do not wear caps, no one's skirt length, make-up or hair style is prescribed. Insofar as possible a college atmosphere is maintained.

Because nursing has been traditionally a female province, it would seem natural to relate the profession's desire for increasing independence and its increasing activism to the women's movement, particularly since much of the rhetoric and the chronology is similar. It is surprising, then, that the faculty, and to a greater extent, the students, do not see the transition in those terms and do not, for the most part, describe themselves as feminists. Jane Edwards says that her women students are much less passive than students were in her generation and assert their independence in ways that are almost embarrassingly right. "Yet while they are equality-oriented, many still talk in traditional terms." One bright student reacted to the word "feminism" as if it concerned traditional femininity rather than women's rights, and when the terminology was clarified she saw no appropriateness to the analogy. "We have nine men in our class," she said. "It is the profession that has goals, not just its female members."

It is also interesting to note that in these days of the women's movement, when it is now valid to ask even female students in a health profession why they did not choose to be physicians instead, the nursing students, male and female, seem to have a very good idea why they chose to become nurses. "What really interests me in health care," says Susan Loughery, "is people. I like to help people on a personal level, and a nurse has more contact with patients on this level than does the more scientifically-oriented physician." It was in great measure nursing's state of flux that attracted senior Ray Furlong to the profession. Furlong, who is 31, who already has a bachelor's degree from Georgetown University, who is an alumnus of the Peace Corps, and whose father and brother are both M.D.s, remembers he faced precisely that question at his Jefferson interview: why, especially since you already have the bachelor's degree, aren't you applying to medical school? "In nursing," he replies, "the roles are not already established. You can find a situation which agrees with you and you have a chance to influence the way the new roles will evolve."

It is somewhat difficult to measure how well reality matches the expectations of the liberally-educated and independence-oriented B.S. graduates. By anyone's definition, it is clear that the nursing profession has come a long way from the days of Jane Edwards' Duke University training, when a nurse in the South didn't just take orders from physicians, she was even required to forego the compensatory benefits of traditional etiquette to reinforce her subservience.

"If a male physician came into a crowded room," she recalls, "the female nurse was expected to give up her seat to him."

Do, however, the Jefferson B.S. graduates find that they are allowed to function as they have been trained to function? Although some compromises do have to be made, it would appear that the answer is a qualified yes. "It is often frustrating for the new graduate," says Dr. Voss, "to begin a staff or floor nurse position, where the graduate may find that the opportunity is just not there to utilize his or her education to the fullest. This is probably one reason so many B.S. graduates go into public health nursing. The field has proven to allow the greatest opportunity for independent work." An Associate Professor finds that the initial three to six months seem to be the most difficult for the new graduates, but once necessary adjustments are made the alumnae she has spoken with feel their expectations have been substantially met. "Most encouraging of all are the stories of our graduates working constructively to change their environments for the better. One former student at a clinical agency, for instance, told me she was dissatisfied with certain of its practices. Rather than put up with it or become abrasive she is doing what we have always tried to encourage. She is researching the problem thoroughly and will make an intelligent
"Did you see that headline for the article about the rise in illegitimate births?" Dorothy Brooten asked two of her baccalaureate students on rotation at Pennsylvania Hospital's Labor and Delivery unit. "That Was No Lady." All three grimaced and half-laughed rather wearily. "That is so bad," the male student said and the others nodded.

He was not referring to the quality of the pun. If there is one characteristic that all the diverse members of the B.S. classes and their professors seem to possess in common it is respect. It soon becomes clear that the humanistic values the B.S. program emphasizes are more than catch phrases; and the mutual respect for peers as individuals carries over to a very refreshing, uncensorious respect for patients as individuals.

Associate Professor Dorothy Brooten feels that one of her major responsibilities is to expose her students to many different points of view, which is not difficult considering the range of student backgrounds. A discussion of abortion or any such controversial subject, Mrs. Brooten notes, can rapidly become heated and polarized. "Most of our students are very aggressive and very verbal. Nursing today can use that aggressiveness, and we don't want to quash it in any way. We see our job more as channeling it constructively, helping the student make the transition to tolerance and, we hope, to tact."

Mrs. Brooten began her own career in a diploma program and worked as a general duty R.N. for several years before returning to school. It took her six years of part-time and full-time study to get her bachelor's degree. She now holds an M.S.N. in maternal-child health and has taught in both the Medical College of Pennsylvania diploma program and the Gwynned Mercy Associate degree program. She has been at TJU since the B.S. program began.

The Department of Nursing stresses professionalism, and Dorothy Brooten would seem to fit anyone's idea of a very desirable role-model. Articulate and enthusiastic, she conveys all the personal warmth a woman in labor would hope to find in her nurse along with unmistakable professional acumen and the self-confidence that gives patients confidence. She is an active researcher, working now on a project using forced answer questionnaires to measure women's expectations and desires in prenatal instruction, labor and delivery. Her first book, The Childbearing Family: A Nursing Perspective, written in collaboration with a friend at the University of Pennsylvania, will be published in March.

Her students, it would seem, find her far from unapproachable. Several on
the labor and delivery unit, for example, discussed the group's recent decision to present her with sergeant's stripes to complement her scrubbing greens. "My only complaint," she laughs, "is that someone else got the general's bars."

As a professional with personal experience in three different approaches to nursing education, Mrs. Booten makes her distinctions and explains her choices once again with characteristic respect. "Most of the leaders in nursing today came from three-year schools. These schools have made an immeasurable contribution to our profession. I personally chose to teach in a baccalaureate program because I felt unable to define my role as a diploma nurse. I knew a great deal about signs and symptoms, diagnosis and medical management, skills that overlapped with those of the physician and thus skills that to a great extent I was not permitted to use fully. Rather than being a mini-doctor, I wanted to help the patient begin to deal with his situation. And the best preparation for this uniquely nursing function is a baccalaureate education."

The three Jefferson programs are not the only options available to prospective nurses today. The Associate degree in nursing, offering two years of college credit and preparing those who complete the course for essentially the duties of a technical nurse, is becoming increasingly popular. Hahmemann, for instance, recently dropped its diploma program for an Associate degree course. Another variation, known as one-on-one, available, for example, at Presbyterian Hospital, combines the practical nursing course with an Associate degree. Everyone enters as a practical nursing student, but those who qualify can complete a second year for the Associate degree. Both of these alternatives would be difficult at this time for Jefferson to adopt, because they include liberal arts courses.

Last year's Middle States evaluators commented that three separate nursing programs in one university is an unusual practice, and recommended that Jefferson form a committee to study the situation and determine more precisely the University's goal in nursing education. The matter is complicated by the fact that the practical and diploma nursing courses are the only two Jefferson programs that do not lead to a college degree.

Whatever the ramifications of the committee's conclusions, it is clear that education will become increasingly important to the nursing profession. While a master's degree in nursing is currently satisfactory background for teaching in a B.S. program, administrators within and without academia are usually expected to have Ph.D.s. Degree-consciousness would seem a natural byproduct of increasing professionalism, but it reflects more importantly the pertinence to nursing today of the broader vision an advanced degree ideally implies. Nursing has reached the point where many in its own ranks are recognizing that they have a unique contribution to make to the health care system. As Jane Edwards notes, however, the need now is to make the public and others in health care delivery aware of how much the professional nurse has to offer.
It was a day in February, 1975 and I was moving out of the basement office which had been the Dean's lair for the first four years of development at the Rockford School of Medicine. In the process I spotted a program for the AMA Congress on Medical Education in the mid-1950's.

Leafing through it, I came to some notes made during a talk by Dr. John C. Leonard, who was the nation's first Director of Medical Education (at Hartford Hospital). The notes recorded what was perhaps his favorite story, about the farmer stopped at his plowing by the university agricultural agent on his monthly visit. The agent was expounding about the value of a book entitled "Modern Farming," and was suggesting that the farmer pay its modest reduced price. The farmer took one look at the cover and said to the agent, "Hell, I don't need that book, I ain't farming half as good as I know how to now."

For someone who had spent 23 years in medical education and medical administration, the story was singularly appropriate. In eight years as a junior faculty member in the Department of Medicine at Jefferson, and 11 years as Vice-President for Medical Affairs for York Hospital and Assistant Dean for Associated Hospital Programs at the University of Maryland, and now for something over four years as Dean of the Rockford School of Medicine, I had to admit honestly to myself, that I wasn't "farming half as good as I know how to now."

While at Jefferson and York, I had spent a great deal of time in the formal and informal study of the educational process and how people learn from the standpoint of the professional educator. I worked with Drs. Stephen Abrahamson, Edwin F. Rosinski and George Miller at the University of Buffalo in the '50s, and continued study with a series of short formal courses and a great deal of reading in the subsequent years. As a matter of fact the curriculum, evaluation and educational philosophy of the Rockford School of Medicine was a result of this interest. The continuing performance of Rockford's graduates both on the internal examinations of the University and on the National Boards bears out the educational propriety and competence of the program, measured by anyone's standards.

Recently, however, and brought into particularly sharp focus by a just completed (January, 1975) retreat of the five Deans and the Executive Dean who guide the activities of the five Schools of Medicine which make up the College of Medicine of the University of Illinois, it had become evident that educational excellence alone was not enough. There was serious misunderstanding and difference of opinion on the best business procedures, the best methods of accounting for and directing the expenditures of budget, and even such basics as the process of budgeting itself. Having operated two businesses, and with more than a passing acquaintance with accounting—certainly more than the usual physician/administrator—it was evident to me that what we were doing was neither efficient nor appropriate to utilizing funds in the most efficient fashion to educate students and to deliver health care, the latter being a major goal of the Rockford School of Medicine.

It was also uncomfortably plain that deans in today's world, and most of today's medical administrators are singularly dependent upon technical experts in accounting, electronic data processing, and in the systems which produce decision-making information for management. My personal reaction was to feel acutely uncomfortable being in charge of a multi-million dollar institution, and being dependent on most of the data that is absolutely vital to decision-making coming from highly technical sources. These sources I could not completely validate personally, and the accuracy of which could not be proven until long after the decisions already had been made. The personal need to build some knowledge for independent judgement in these areas was overwhelming.

I remembered that three years before I had attended a ten-day course in Systems Dynamics Analysis (the science of using computers to model functional systems for production, education, or health care) at the Massachusetts Institute of Technology. At the just completed Deans' Retreat in Clearwater, Florida several of the MIT faculty were serving as consultants from MIT's Sloan School of Management to the Associ-

Dr. Evans reports on his year as an Alfred Sloan Fellow at MIT's Sloan School of Management in Boston. He recently has accepted the position of President and Chief Executive Officer of Cooper Medical Center in Camden, New Jersey. Dr. Evans completes his second three-year term as Alumni Trustee on Jefferson's Board in June, 1977.
of American Medical Colleges Council of Deans. When it was obvious that I had “agreed to disagree” with the Illinois “system,” at least two of the MIT professors had spoken to me about becoming, for a year, an Alfred P. Sloan Fellow at the Sloan School of Management, and the idea and possibility intrigued me.

The Alfred P. Sloan Fellowship originated in the 1930s when Mr. Sloan was the Chairman of the Board of General Motors. Mr. Sloan had the fear that American industry was even then becoming dangerously in-bred at its upper levels of management. He established and endowed the Sloan School at MIT, initially to study labor relations. Very soon after its founding, however, Alfred Sloan moved on to utilizing the School for one of his remarkably prophetic insights into the American industrial scene. He felt that it would be most important to establish a course, one year in length, to which major American industry might send those middle career executives who had been identified as the future chief operating officers and executive officers of their corporation. It would be an experience which would broaden and deepen their understanding of American life, the arts, law, society and industry. The Sloan Fellowship was the result.

It has slowly evolved over the last 40 years into a polished and incredibly absorbing and fascinating year for the middle executive and his or her spouse and family.

The Fellowship starts with an intensive period from mid-June until Labor Day, which can only be described as an “intellectual boot camp.” It is concerned primarily with basic English law and European civil law, anti-trust, patent, liability, environmental, and equal opportunity law, accounting and computer applications, quantitative analytic mathematics for decision-making, and economics, both international and at the level of a single industry or business. Following that summer are a pot pourri of courses in the areas of quantitative analysis, continued computer definition, finance systems for raising and investing funds, organizational growth and development, organizational psychology, the use of computers in modeling industries, institutions and systems. Included is a superb course of readings in power and responsibility, which covers the great writings down through the ages that have had major impacts on the structure and functions of our civilizations. Salted through the period from September until May are a series of twice-weekly “shirt-sleeve” seminars, lasting six hours, with the chief executive officers of 80 or more of the nation’s top 500 corporations.

“Alfred Sloan … established a course, one year in length, to which American industry might send those middle career executives identified as the future chief operating and executive officers.”

Three field trips occur. The trip to Washington includes a briefing by the Brookings Institute and a half-day each with the Vice-President, a Supreme Court Justice, several of the cabinet level officers and the directors of many of the departments, together with a selected few influential Congressmen and Senators. The trip to New York allows twice daily seminars with the Presidents of AT&T, IBM, City Bank, Chase Manhattan, and twenty similar New York-based corporations. The final field trip occurs during the last month, after completion of the thesis, and is a trip through Europe and the Middle East with an opportunity to hold seminars with Ministers of Finance and Health and to visit central Europe, Russia, Algeria, and Britain, in depth, from the standpoint of both finance and industry.

Each of the 50 Sloan Fellows is accompanied to Boston by his or her spouse. The family is required to take residence in Boston and it is expected that at least once weekly they will attend a seminar on the arts and sciences or a seminar concerning the Sloan Fellowship itself. In the latter, the spouses have an opportunity to learn what is being taught to their husband or wife and why, in addition to working with their partner at a whole series of arts and science seminars featuring the major conductors, museum directors and others from the New York and Boston areas.

The opportunity to be one of the 50 couples chosen from several hundred applicants and to have some scholarship support while continuing on terminal salary from the University was far more temptation than Peggy and I could withstand. We journeyed through the snows of early April and the closing of O’Hare Airport, to enter the annual “New Sloan Weekend.” This is a three-day period when one of the Sloans in the present class hosts a new Sloan in a mad scramble to find appropriate housing from the long list available at MIT, to get a chance to know “what it’s all about,” by meeting the faculty and one’s own classmates. It is a weekend characterized by a spirit which pervades the entire Sloan program—competent organization, and a warm sense of “can do.” Advice is available in large quantity and has withstood the test of time as amazingly accurate—not inconsistent with the capability of the individuals who are completing the Sloan program for that particular year.

Nothing would be more pleasant than to tell you many “war stories” about our year as Alfred P. Sloan Fellows. The class was composed of business people at the Vice-President level or higher in major American, Japanese, South African, British and German industry, a few full-time federal employees, and five people from the health field, including another Dean, an Associate Dean, and two administrative nurses. This group of fifty couples worked together, lived together and survived together for a year, and I’m sure we’ll always remain together in a way that only an intensively shared experience can produce.

The workload was almost incomprehensible. Much of the time it consisted of 1,500 to 2,000 pages of reading and 20 or more hours of calculation each week, beyond the six hours of classroom work a day. It was particularly traumatic early in the summer while the “over achievers” and “workaholics” began their competition, and then slowly, with great wonderment realized that the summer was designed to so overload
them that they had to learn to work together and to apply a team effort simply to accomplish even a portion of the learning assigned.

Being by five years the oldest Sloan Fellow that had ever been accepted, I was acutely aware that much of the faculty had doubts as to whether anything of significance could be learned after 45. There was the possibility that the enrollment of other "older" middle management people, as characterized in the health industry, might well depend upon my performance. It is nice to note that this year there are more people in my age group in the program.

The groups we worked in were euphemistically entitled "car pools" and did, in fact, bear some slight resemblance to that great American institution. My particular group consisted of a Vice-President for Labor Relations from the Bell System, the Vice-President of British Steel for Personnel Relations, the Chief Physical Scientist for Army Anti-ballistic Missile Weapons Systems and a Norwegian attorney who is Vice-President of the largest tanker and investment house in Norway. They were all in their mid-30s to early 40s, and we became an intensely close-knit, inter-dependent group, which even today is in contact at least monthly. We also developed close alliances to many other classmaties and their "car pools." This is all intensified, measurably, by the fact that the Sloan group represents 50 couples, and their families, in Boston for a year, from all over the globe, with few, if any, local contacts and an intensive work and social schedule. These produce an intensity of communication and a depth of understanding of each other which I’ve rarely seen in any group. For instance, I still get calls from all over the nation to "just be sure" about some medical question. I confess that I also have my own series of class experts on labor relations, information systems, investment philosophy and organizational structure. Each is only as far away as the closest telephone, and is quite willing to drop whatever he or she is doing for a brief exchange of information and a genuine amount of affection and inquiry of a personal nature about Peggy and the boys.

This experience is obviously vital in terms of personal involvement and tremendously productive in the transfer of understanding of what American industry is, of what it can do, of what our business neighbors are like, and of what systems they have that we might use and what approaches we have that might be used regularly in business—and both transfers occurred.

How does all of this relate to medical education, to medical management and to "farming as well as we already know how to"? Let’s take a few moments to look at what we know is available to help us with our work of health care and health education and which we presently are not using. Let’s also apply, at the same time, some thoughts that occur from the Sloan business and management experience.

In undergraduate medical education today, the common system is the classic mode of Osler and Johns Hopkins. In hospital administration, most of our schools still teach the classic MacEachern system. These have worked for decades and have produced many thousands of fine physicians, competent administrators, most of whom are still alive, though perhaps not existing in great harmony. It has also produced the huge, compartmented, academic medical center design which is given to the necessarily infinite detail of investigation and which has established a cost and availability pattern for health care unacceptable to our people and our legislators. These thoughts are fact, not judgement.

Should we discard these systems? Obviously not. To do so would be far more fatal to our future freedom on function than the slow demise which we are bringing about by blind support of this system. The present units, beautifully typified by the Jefferson University Complex, must remain viable and strong. For these units are basic to any system which will provide education, scientific research and the new fourth level of complex care which we are rapidly approaching with whole body scanners, organ transplants and a host of other major techniques.

However, do we really need so much of this great and good thing? Must everything we build to buttress this system and to produce more physicians be so complex or pervasive? Should all aircraft be 747’s and all motor cars Rolls Royce’s? While major units are necessary, there are already more than 90 of them, and what should be the planned structure of the total system of medical education? Obviously the major units presently in existence must be supported to insure a continuing steady downpour of the fruits of research and basic disease and function. As our population growth slows, which it is doing rapidly, its number and size will stabilize, and in a free system as need and demand equilibrate, we shall have to match what we have to what is needed. Thus, the system will need to be small enough to lower the intolerable costs which presently press upon our economy and our people. It was John Gardner who said, "Where human institutions are concerned, criticism without love brings destruction, but love without criticism brings stagnation."

There are affordable, competent, proven systems which provide sane and feasible alternatives to future construction of any more huge academic health centers, which all too frequently become a collection of individual sovereign states, rather than a functional whole. Jefferson and Penn State have led the way for 20 years in their five year curriculum. Northwestern Illinois, Michigan, Kansas, have all within the last five years developed programs similar to that at Rockford. Rockford itself has been around long enough so that its graduates, taught solely by a practicing faculty, have had the opportunity to continue to score well above the norms on internal and external examinations. Indiana has
shown that community hospitals can become teaching hospitals, and all show that the day-to-day costs of teaching medical students can indeed be lowered.

Obviously, to do something which would destroy or damage our present medical centers would be ridiculous. To continue to build further units in their image would be equally destructive. These units, however, working with less traditional remote site campuses or free-standing schools, can shorten the number of years to completion and make medical education far less costly to our public, while producing physician students who

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will have undergraduate, graduate and continuing education options available to them that do not presently exist. Truly competent and educationally oriented, audio-visual, small group and computer teaching can stretch out and reach the practicing physician in his home or hospital with great ease. A small start is seen in the American College of Physicians self-learning series of microfiche films and cassette tapes. This is an important scratch in the surface, but so much could be done by systems for continuing education, resembling the agricultural agent's system, that led to Dr. Leonard's humor.

The economic problems of our society and the present resistance to change displayed by our academic, professional and political leadership will delay what now seems to all of us as inevitable—national health insurance. This delay, however, will create in all of the outside forces pressing upon our industry a much greater determination to over-haul completely health care in the nation. As Sloan Fellows, we spent time with a leading and powerful political figure who is an evermore respected spokesman in the political arena regarding health care. His theme was a two-hour litany of over-building, replication and inefficiency. We can deride it as exaggerated—which it was. But, however polemic, it was believed, at least in part, by much of the Sloan class, people who will become the directors and chief officers of the great American corporations which so heavily support our health system. They could be very difficult antagonists in the future.

Why would an intelligent group accept such a litany? Obviously, because there is sufficient small truth to serve as the foundation for the building blocks of overstatement and exaggeration. Educated people will accept some basic truths. As a profession, we had best soon remember that the average citizen of the United States now has 13½ years of education (halfway through the second year of college). College degrees are more common than high school degrees were thirty years ago. This audience will always listen, and even if it is sure that there is exaggeration, it will worry about the base on which that exaggeration was built.

The Chairman of General Motors has noted that the single largest supplier which General Motors has is the Blue Cross-Blue Shield System. This year General Motors will spend more than $1 billion for health for its employees. This amounts to several hundred dollars per automobile and is more than the metal which makes up the car costs of any of the “Big Three” manufacturers. When the world's largest manufacturer seriously studies self-insurance to lower its costs, we had best do something about the costs!

What can we do? Certainly our students have heard the rising acrimony and more and more they are moving into continuing care specialties, too often, unfortunately, over faculty protests or passive or active resistance. Our inside/outside count of how many of these programs are in our academic centers and how many are peripheral or remote, shows us how little depth of support there is amongst most faculty staff and committees. In this Jefferson is singularly fortunate and perceptive in having long ago established such a continuing comprehensive, personal care unit within its walls.

Another example rests in the field of labor relations. We all know the dramatic impact that unionization of hospital employees has had on health care costs, wherever it has occurred. It continues to occur with frightening rapidity. Yet in front of us we have the examples of IBM, Texas Instruments, Motorola, Kodak and many, many others—each a large multi-national corporation which has remained non-union, by remaining in vital and productive communication with its working group. There are techniques here which would stand all of us well. One of the most interesting pieces of industrial literature I have ever seen, is a comic book in Spanish, produced by Texas Instruments for one of its Texas plants, which explains the philosophy and facts of capital reinvestment to Spanish-American workers whose native language is and remains Spanish. By using “Rosie’s cantina” as an example, it explains allegorically why Texas Instruments needs to put much of its profit back into plant expansion and growth, and how this provides more jobs and higher salaries. It does so without talking down to or patronizing the employees. Compare this with the fact that most of the employees in any of our hospitals, large or small, have no idea that Blue Cross pays a per diem rate and is not close to paying the patient’s bill as it is itemized. In asking this question, I have found many physicians and nurses who do not understand that in our current economy most of our hospital income is controlled outside the hospital and in many states is virtually a completely political function. I cannot help but grant our employees the intelligence to understand how this might impact on their compensation and job security—in a way unionization won’t cure!

There is no need to review the sordid history of duplication and replication of equipment which has characterized our industry. Not even a newspaper delivery boy, let alone an editor, could see the need for three linear accelerators in Rockford, Illinois, or eight major cardio-vascular surgical centers even in such a magnificent medical complex as Boston. Industry, which is legally prevented from cooperative efforts amongst competing firms, would have
come intuitively to an understanding that would preclude such suicidal competition. There is probably still time for our hospitals to learn to do this, particularly when they do not have the legal prohibition that faces industry in terms of cooperative effort.

The present system is as functional and economically efficient as a submarine with screen doors. We are forcing our patients to make the choice amongst us as competitors which the patient doesn’t really want to do. Then we are getting terribly angry when he: 1) doesn’t understand our demand for more goodies; or 2) picks the “wrong” competitor on which to bestow goodies! The need to be functionally efficient and to produce a profit in order to stay alive helps industry. I can’t help but feel that it may not be long before the same need to stay alive will affect our decisions in the health care industry. It would be nice if we could do it ourselves. It might prevent us from losing our independence (which remains) with all flags flying and an epitaph that says, “They could make major decisions affecting the lives of others, but could not learn to divide their own supply of tootsie rolls.”

Finally, let’s talk a little bit about management in our health related institutions. Our MIT degree thesis examined planning systems, management information systems for decision-making, and management control systems for implementation of those decisions in medical schools. The two of us who were medical Deans and Sloan School Fellows could find evidence in only two of 30 medical schools that functional systems utilizing reasonably easily gathered information were being used to support decision-making. Only two systems for strategic planning existed, though “long range planning committees” abounded.

We reviewed unionization in hospitals above. Otherwise, with some clear exceptions, our hospitals are philanthropic successes, and financial sponges, and fail miserably in the area of empathetic judgements concerning patients. There are existing cost center and income center mini-computer systems which applied to our universities and hospitals, could provide us with the information needed to both lower our costs and make our decision-making both more effective and more efficient. One can now buy a pocket calculator for $200 which will do most of what an IBM Central Processing Unit costing $2 million did five years ago. A fully integrated mini-computer system will now capitalize for less than a year’s rental for a system of equal capability three years ago.

Hospitals are an extremely labor intensive industry with much repetitive involvement in paper and reports. Competent studies have shown that nurses spend as much as 60% of their time producing paper and pencil reports. Simply cutting this effort in half would produce the equivalent of about one-third more nurses at the R.N. level, or better yet, release 30% more R.N. nursing time for direct reaction with patients as frightened and uninformed people.

_"We must abandon the philosophy that only we as physicians or hospital administrators know what is best for the system. Our minds are finite but the information available to us in the area of business function is almost infinite."_

We have, within our immediate capabilities, ways to reduce the non-patient contact time of all of the health professionals in our patient care system. Certainly, the use of some of these techniques will change some of the present management relationships but it will substitute for them a more thorough understanding and communication amongst the people who form the group really responsible for the delivery of care at both the ambulatory and the in-patient contact level. As physicians, we occupy a major decision-making role in both hospitals and medical schools. We must stop making these decisions intuitively and learn that if we insist upon it, we can get accurate data, that will much more clearly point our way. To use a simile—no matter how well we can actually handle the automobile as driver, we may not know best how to provide direction or chose the shortest route. If we are to have a major role in helping people we need to know best how to bring them together and pick them up so as to move them with us in the same machine in the same direction.

An intensive year in the business world has proven (and I was a deep skeptic) that it is possible to combine the best of our present professional management with the factual, intellectual and quantitative systems of decision-making that characterize what is best in American industry. By removing some of the factors of chance in our decision-making, we may preserve the opportunity to continue to express leadership and purpose in the health care system. We must abandon the philosophy that only we as physicians or hospital administrators know what is best for the system. Our minds are finite, but the information available to us in the area of business function, is almost infinite. We must choose to use it, and to process its data mass in a way to apply it constructively for our institutions.

It was Winston Churchill who said, “He that leaves nothing to trial will do few things poorly, but will accomplish little of significance.”

There are many ways of learning more about the things discussed herein. They range from one week courses to two year courses. There are home study courses, group study courses, and individuals who will come into your hospitals and put on courses for you. At a time when how we manage our resources may become more important than what the resources are, it would seem vital to know a little more about resource management and data based decision-making and to be able to plan systematically and strategically for the future.

It is not too late for us to begin developing the individuals who must competently head our health care system in the future and who have an intimate knowledge of medicine and/or nursing and an in depth knowledge of management techniques, philosophy, psychology and quantitative decision-making.
Community Mental Health: The Daroff Experience and the Medical Model

by

Theodore W. Wasserman, M.D. '61

Our experience with community mental health was Jefferson's, and Jefferson, after two years of planning, opened a community mental health center in 1969. We didn't know it at the time, but community mental health at Jefferson was to have a great impact on our professional lives. I had just completed my Jefferson psychiatry residency where I had served as chief resident; Dr. Timothy J. Michals '66, my associate, was just starting his psychiatric training at Jefferson. Three years later, I was studying for Boards and Tim was chief resident in psychiatry. We had left "Mecca" and found ourselves dazed by the new psychiatric revolution at Fifth and Reed Streets, (Daroff Division of Albert Einstein) in another place, at another time.

Here is what happened:

Community mental health in Philadelphia brought many changes to the practice of psychiatry. In seven years, there was a dramatic shift of treatment facilities, from remote locations to people's "back yards." People were no longer "put away" from the sight of others, from their families, their friends and their jobs. The impetus came from Federal law. The Community Mental Health and Mental Retardation Act of 1966 set a precedent of federal funding for treatment, as opposed to research or education. This type of "program funding" fostered rapid growth of therapy programs and ran counter to traditional fee-for-service medicine; socialized medicine had arrived.

The Community Mental Health Center Act stimulated new interest in the treatment of psychosis. Heretofore, treatment of major mental illness was largely a responsibility of the State and municipal hospital systems. State hospital admissions and patient population have been drastically diminished. The fastest growing hospital segment has been small units in general hospitals. Psychiatrists were returned to general medicine. The shift of patient population from outlying State hospitals to community general hospitals has exposed young psychiatrists to their colleagues in medicine. Treatment approaches, which were predominantly psychological, have been solidified by genetic, epidemiological, social and pharmacological methods.

New delivery systems have emerged as the Mental Health Act required emergency treatment, day hospital and clinic programs. These intervening and crisis oriented methods have offered adjuncts to, or substitutes for inpatient treatment. Emergency treatment and crisis intervention were updated and expanded. In 1968, emergency treatment meant a ride in a red car (remember them) to an emergency room and from there to the State Reception Center at PGH, prior to five or six months average stay at Byberry. "New" clinics have developed. In the old traditional clinics, psychotic patients, discharged from State hospitals, were seen once every six weeks and "private treatment" neurotic patients were seen six times every week. In the new clinics, discharge psychotic patients are seen weekly or twice weekly, and neurotic patients are hard to find.

This brief review of the community mental health center movement in Philadelphia is not designed to be a critique. Our training represented the culmination of a 25 year post World War II era in psychiatric education. The early proponents of the community mental health revolution were very critical of our new profession. In 1969 and 1970, at meetings held in the Davis Clinic and in the Medical College, we were witness to assaults on what was called "the medical model." The term was often equated with a capitalist, racist, rich, powerful body of medical people (mostly psychiatrists) who stigmatized people with diagnoses, took all their money, removed their civil liberties and locked them away in State-run torture chambers to be forever forgotten. It was alleged that this medical establishment guarded its expertise zealously, never allowing any trade secrets to escape to the unenlightened masses. The attack came from within and without. We heard that mental illness was a myth, that treatment was undefinable,

Dr. Wasserman, Chairman of the Department of Psychiatry at Daroff Division, Albert Einstein Medical Center, is Clinical Assistant Professor of Psychiatry and Human Behavior at Jefferson.
Dr. Theodore Wasserman: Humanistic concern is crucial to the healing arts.

that therapy required no education, that there were no rules, no boundaries, no real body of medical psychiatric knowledge. One popular self-designated "therapist" when asked about his training background, replied "All the training I needed was toilet training." Even that was doubtful.

Despite the long tirades against the medical model, we were hard put to find any documentation in the literature, for or against. Ralph Littlestone, Chief of the Planning Branch NIMH, wrote "One common framework for planning mental health programs is based on a medical model. This formulation, particularly associated with the mental health field, has several defects. Aftercare is essentially equivalent to post State hospital care. This places the hospital at the center of the mental health universe. The model tends to ignore the importance of essential non-medical services and it omits prevention as an ingredient in the range of mental health services."

We have some of our own thoughts on the medical model and the role of the therapist in the delivery of mental health services. A "therapist" can come from any of the treatment disciplines: psychiatrist, psychologist, social worker, nurse, alcohol treatment specialist, etc. The medical part of the model involves a philosophy of treatment, applicable to all groups. Aftercare is treatment and we assume that Littlestone's reference to "non-medical" indicates housing, nutrition, recreation, rehabilitation, re-socialization, etc. These approaches are, in the medical model, the responsibility of the therapist, who either performs the service directly or sees that his patient receives it. We are not referring to teams or community responsibility or other "let George do-it-isms." We are talking about a special attitude, a commitment that has evolved over centuries and has served as the foundation for the medical doctor-patient relationship.

This central theme of the medical model lies in the therapist-patient dyadic relationship, one person caring for another. Humanistic concern is crucial to the healing arts and a part of psychiatric tradition, in particular. The therapist assumes a longitudinal, primary care responsibility for his patient. Psychiatry is a medical specialty and fits naturally into the primary treatment medical delivery system. The therapist functions not only as the first person to see the patient, but also as the person responsible for continuing care, as skilled friend, reality contact, confidant, translator or referring individual.

The use of psychiatric terminology should not be a source of concern over stigmatizing patients. Properly used, it enhances accurate description, treatment planning and research. In an indirect way, the terminology supports confidentiality without compromising concern for the patient as an individual. Treatment should be designed to help, not harm. This simple concept borrowed from Hippocrates (along with a number of the other aspects of the medical model) can be terribly distorted. A recent movie "One Flew Over the Cuckoo's Nest" is a good example of the punitive role attributed to the treater of mental illness.

Colleagues in therapy should be accepted and treated with special respect. The battles in the old psychologist-psychiatrist civil war are antitherapeutic, to
say the least. The recent introduction of large sums of federal money as spoils, has fanned the flames of interdisciplinary conflict. In the same vein, learning is meant to be shared. Teaching is not a privilege of the therapist. It should be viewed as a requirement, for therapy is, in itself, an educational process. The word doctor by no coincidence derives from the Latin verb “to teach.”

The alleged absence of prevention in the medical model requires elaboration. The community mental health movement borrowed three terms from public health: primary, secondary and tertiary prevention. The first pertains to removal of potential disease causes, for example sterilizing milk or water to prevent bacterial or parasitic diseases. Secondary prevention means early case finding and averting recurrence of symptoms. Tertiary indicates maintenance of the patient with irreversible disease process. The art in psychiatry had far outstripped the science, until the last 25 years. The focus has been shifted from tertiary to secondary prevention, through the use of newly developed psychotropic drugs and through the community mental health movement. The etiological factors in mental illness are not sufficiently elucidated at this time to provide for primary prevention in the true meaning of the term.

Armed with the recently acquired tools of our trade, and riding the crest of the community mental health tidal wave, we made our way to Daroff in September 1972. Daroff is a 75 year old, community hospital, located at Fifth and Reed Streets. It is in the center of a blighted area of South Philadelphia, surrounded on four sides by rundown, dilapidated row houses. The population served represents numerous ethnic groups and still portrays today, the melting pot, turn of the century demography present when the hospital was founded. Its original name was Mt. Sinai Hospital, then Albert Einstein Medical Center, Southern Division in 1952, and more recently Daroff Division. To the neighbors, it is still called the Sinai.

There are 210 total beds, 22 psychiatric and 35 combined alcohol and drug detoxification. We started a 20 bed interim locked unit in September 1972, and moved to the present, totally refurbished 22 bed inpatient unit in January 1973. The space was previously an obstetrical floor. The delivery room, where I was born, became my office. The nursery became a combined dining room/activities room. Our initial clinical service had no house officers and a green staff. We were pretty green too. Tim completed his Jefferson psychiatric residency in January 1973, the last three months at Daroff. Most of the early patient referrals were from the Jefferson emergency room, as the 12th Annex there did not open until February 1973.

We shared an evening and weekend schedule of every other week on call. The charge nurses took all incoming referral calls à la Rachel Clark, on Jefferson’s 14th Annex. Everyone on the staff learned mental status examination, psychiatric history recording, nomenclature, drugs and commitment law. Nurses and technicians saw all emergency room consults. We listened to presentations, checked findings and supervised. As we taught we learned. I passed my Boards in October 1972 and Tim passed his in October 1975.

In July 1973, we were assigned our first psychiatric resident, and in January 1975, the first Jefferson medical students arrived for junior clerkships. To this, we added teaching rotations for Jefferson and Einstein nurses, also Lower Bucks County nurses and we have just begun a clerkship for art therapy master’s degree candidates from Philadelphia’s Hahnemann Medical College. About
30% of psychiatrists’ time is now devoted to teaching.

We never agreed to do anything but start and run an inpatient unit, but by mid-1973, we began doing outpatient follow-up. The pressure to provide aftercare came from the patients. Many of them had never had the opportunity to see the same therapist both in the hospital and clinic. Most of the patients had numerous hospitalizations in State hospitals and also community mental health centers. They wanted “private” care. We like that and happily dispensed with the concept of “ward.”

We didn’t know much about space requirements in 1972. Being Jefferson trained, we could function under adverse conditions. In the old Curtis Clinic, when the weather was hot and the air conditioning broken, the windows opened in such a way that you could simultaneously listen to your patient and the two adjoining therapists and their patients. We made studies in our knowledge of sensory overloading and laid the groundwork for a direct form of PSRO. At any rate, there was no office space for our new clinic, so we saw people on the inpatient unit. Clinic days were a combination homecoming, be-in and mini day hospital. Everybody liked it. The patients got free coffee and Danish and kiddibitzed with nurses and former buddies still on the unit. The staff could not believe what they saw and heard. People in seclusion one month appeared well the next. The concept of remission really turned people on and we recognized that what we had taken for granted, exacerbation and remissions or a longitudinal approach to the course of illness, was virtually unknown to the inpatient personnel. They were missing all the fun.

In 1973, Daroff purchased St. Alphonsus German Catholic Church. The stained glass windows were still in and the pews and confessionals were going to be sold. We went over to snoop around and toured the Pfarr Schule, the parochial school. There were classrooms on the second and third floors and an auditorium on the first floor—a ready made day hospital and clinic under one roof, in a building separate from the inpatient unit. They wouldn’t let us keep the confessionals though!

The Day Hospital opened in August 1974, and we moved the clinic in September 1974. We hired four therapists for the day hospital, two R.N.s, a social worker and a psychologist, all women and all mothers. Each had at least a year of inpatient experience at Daroff. We developed a training schedule, modeled after psychiatric residency. By the end of the first year, they each had 150 hours of combined individual and group supervision. They were encouraged to see selected outpatients to further their knowledge. Day hospital and clinic groups were designed to overlap, providing further continuity in treatment. There are now 28 group therapy sessions per week in the day hospital and clinic. Day hospital therapists are active in evaluating new cases, including emergency room requests, can admit to the inpatient unit and make rounds on inpatients, as well as run assessment groups for day hospital prospects.

The Daroff Day Hospital is the first Medical Assistance approved free-standing Day Hospital in a private community hospital in the State of Pennsylvania. Day hospital patients are seen individually at least three times a week. The therapist-patient relationship is stressed as is continuity of treatment. The treatment day is 9:30 a.m. to 3:30 p.m., Monday through Friday. Day hospital patients are seen by a psychiatrist a minimum of once every two weeks. Appointments for these visits, extra supervision, family or conjoint therapy are the responsibility of the primary day hospital therapist.

The move of the clinic to the Pfarr Schule caused an isolation of the inpatient unit, except for therapists making rounds and assessment groups. In January 1976, we began a three month rotation for inpatient nurses through day hospital and clinic. It is designed as a purely clinical learning experience, no report rituals, no night duty. Psychiatric technicians will also begin a similar rotation in the near future. In September 1974, we added an alcohol treatment specialist to the staff. The alcohol program was incorporated in inpatient, day hospital and clinic programs. At this time 15% of ambulatory patients plus 12% of inpatients have alcohol related illnesses.

We have expanded our M.D. staff to four Board Certified psychiatrists, one full-time psychiatric resident and a half time internist. Our acceptance by the other staff physicians has been heart warming. I am President of the Medical Staff this year, and Tim is Secretary and Chairman of the Credentials Committee. At this time, we admit 400 to 500 inpatients per year. The average stay has dropped from 21 days in 1973 to 17 days in 1975. The occupancy on the inpatient unit was 96% during the last year. Seventy five per cent of our inpatient referrals are referred from the Daroff clinic, day hospital or emergency room. The average day hospital census is 30 patients per day and we have over 300 patients in active ambulatory treatment. We see over 300 hospital consultants each year.

Seventy per cent of our patient population is indigent, yet we have received no grants, either federal, state or county. The “priming money” supplied by the Board of Trustees of Albert Einstein Medical Center compares for our total department (inpatient, day hospital and clinic) for one year to 20% of the annual budget for just a day hospital in a federally supported community mental health center. Traditional fee-for-service doctor-patient private practice, modified and updated, has proven successful as a delivery system.

We could not have accomplished what we did in less than four years without much help. The consultation and education arm of Jefferson Community Mental Health Center supported our program development with ideas and encouragement; our former teachers pressured us to assume responsibility and exposed us to the challenge of new methods of delivery of psychiatric services. Our teaching is, on all levels, integrated with Jefferson’s. As we said initially, our experience with community mental health and with the medical model was Jefferson’s and what started at Jefferson in 1969 was recreated, with our own personal touch, at Daroff in 1972. Community mental health is what was happening then and is happening now at Jefferson and at Daroff.
On November 1, 1976 the Barringer Residence Hall at the corner of 10th and Walnut Streets (below) was formally dedicated to honor two generations of Jefferson trustees: the late Daniel Moreau Barringer, who served on the Board from 1902 to 1936 and his son, Brandon Barringer (right), who has been a Life Trustee since 1936. Mr. Barringer, as Chairman of the Finance Committee, has been instrumental in keeping Jefferson on a sound financial basis for decades. In addition to his numerous committee appointments at Jefferson he also has served as a Director of the Curtis Publishing Company, the Lehigh Valley Railroad, the Wellington Fund, the Philadelphia Suburban Transportation Company and Children's Heart Hospital. The commemorative plaque reads in part "in grateful tribute for long, devoted and distinguished service." The ten floor facility for student housing was opened on November 27.
The Howard Goody family in one of nine three bedroom apartments was one of the first occupants (a member of the class of 1975 he presently is a resident in dermatology). The spacious living room faces the 10th and Walnut Street corner as seen in the photograph on the previous page.

Although the other two bedrooms are not as large as the master bedroom (below) there is ample space for a den for Dr. Goody's late hour studying. At the rear of the building (right) the planted area makes an attractive spot for outside leisure time. The lobby level will be leased as commercial space.
The William Bodenstabs, of Wilmington, Delaware, occupy one of the 54 single bedroom apartments (he's a senior medical student). In addition there are 12 efficiencies and 63 two bedroom apartments in the Residence Hall. There are laundry and locker facilities for each occupant.

The apartment complex is open to all university students, interns, residents and graduate fellows. The facility already is 60% filled. John S. Sabatino Associates designed the building and J.J. White Inc., was the general contractor.
In talking about Dr. Harold Israel, whom he has known for 13 years, Dr. Alan Josselson '73 recalled the trademark of a once well-known Philadelphia radio personality: opinionated but lovable.

"That's Dr. Israel," says Josselson, "with one qualification. He is so bright and so knowledgeable that his opinions are almost always proven right."

Dr. Israel's reputation as a man who seems never unsure is reflected in his early career as well as his present. He grew up in Boston, and after graduating from Jefferson in 1934 he considered returning to that area. "I was in the middle of the internship exam for Boston City Hospital when I was called to the telephone. It was my father, telling me I'd just gotten a letter of acceptance from Philadelphia General. That made up my mind. I didn't even finish the Boston City exam!" He joined the staff of PGH in 1936 and retained his affiliation until 1971.

Through his association with PGH, Dr. Israel worked with physicians from the University of Pennsylvania and was impressed in particular with some of the tuberculosis specialists from the Phipps Institute. He took his residency training there, teaching, doing epidemiologic research and eventually receiving a master's degree in public health. When he went into the army in World War II he felt narrow as a physician after his intense tuberculosis specialization; after the War he started a more general internal medicine practice.

In the course of his career Dr. Israel has taught at every Philadelphia medical school except Hahnemann. From 1947 to 1950 he was Associate Professor of Medicine at what was then Women's Medical College. While Chief of the Graduate School Medical Service at PGH, he was also Chief of Pulmonary Medicine and Associate Professor of Medicine at the Graduate Hospital of the University of Pennsylvania. He returned to Jefferson in 1959 as a Clinical Professor and Chief of Jefferson's medical service at PGH. Although his accolades and accomplishments could be envied by many academic physicians, Dr. Israel has always been a private practitioner and never a full-time member of a faculty. For the last 15 years his practice has been chiefly on a referral basis. He is known for aggressive patient care and great personal concern.

Now an Honorary Professor of Medicine at Jefferson, the physician is enjoying a reputation as Jefferson's "old master" in chest diseases. Contrary to his expectations, however, honorary status has brought no reduction in activity; in addition to his private practice and Wednesday sarcoidosis clinic he has teaching responsibility for pulmonary Fellows, housestaff and junior/senior medical students. In the classic tradition he has a great following of former interns and residents who have over the years been almost mystified, as one observer put it, by his ability to think through a patient's problem. His forte as a professor is bedside teaching; his informal remarks are particularly effective because his rounds are thorough and unhurried.

The physician also has something of a reputation as an absent-minded professor. During one lecture, for instance, he wanted the lights turned off to show slides. As he walked to the rear and flicked the switch he was so intent he failed to notice that a helpful student had already turned out the lights. When he returned to the podium no one was more surprised than he to discover that the lights were still on. Another story is told about one of his less efficient secretaries. For the eight months prior to her discharge she proceeded systematically, but unnoticed, to neglect one of her duties: she didn't send out the bills.

Dr. Israel has also been active in clinical research. After World War II he received one of the first Public Health Service grants for a study of sarcoidosis at the Phipps Institute. He is a member of the International Committee on Sarcoidosis and has published 62 papers on its various clinical and immunologic aspects, as well as 78 papers on tuberculosis, pneumonia, pulmonary embolism and others. He has been interested in particular in the behavior of delayed hypersensitivity skin tests in sarcoidosis and is collaborating with scientists at the University of Pennsylvania and the Wistar Institute in studying the immunologic response of circulating blood lymphocytes of sarcoidosis patients and attempting to isolate a virus from the tissues of sarcoidosis patients. He and Jefferson's Dr. William Atkinson have investigated the fungal disease, aspergillosis. The study's goal is to determine the value of corticosteroid treatment of the disease. "Sarcoidosis," notes colleague William Atkinson, "has always been his project. Part of his success as a clinical researcher has been his tireless persistence in keeping his sarcoidosis clinic patients together. Every Wednesday morning you know without question where Harold is going to be."

Dr. Israel also maintains an interest in tuberculosis, and is currently engaged in the controversial attempt to reduce the use ofisoniazid as a tuberculosis preventive medication. In his view it is unwise to prescribe a drug whose use has been associated with hazard to the liver to prevent a disappearing disease like TB. His interest in the harmful side-effects of drugs is not new. In 1961 the physician was instrumental in recognizing the occurrence of pulmonary disease as a reaction to a drug widely used in the treatment of urinary tract infections, nitrofurantoin.

Noting that his Jefferson position has been his most rewarding, Dr. Israel believes that an important difference between JMC and the other educational institutions with which he has been affiliated is the greater role of the practicing clinician. "I feel many schools have suffered because the full-time faculty has
been overemphasized. At Jefferson we have a greater mix of clinical problems and thus a more varied educational experience for our students.” Dr. Israel was influential in effecting the agreement in the late ‘60s between full- and part-time faculty at Jefferson, an agreement whose details were reported in a national journal as a model compromise.

Since his Jefferson days when he placed second in the nation in a sophomore year national board examination, the physician has been honored many times by his profession. In 1973, for instance, he gave the Solomon Waksman Memorial Lecture of the New Jersey Chapter of the American College of Chest Physicians. This past year he was elected to honorary membership in the elite Solomon Solis-Cohen Society, a 15 member Philadelphia group that asks one representative of each medical specialty to join the Society, for life. The Laennec Society of Philadelphia held a testimonial dinner in his honor in 1975.

Dr. Israel and his wife, Frances, Editor of the Temple Times, are center city residents and enthusiasts, who take advantage of the theatres, concerts, museums, etc. that seem to be sufficient recompense to increasingly fewer for urbanity’s less uplifting aspects. He has also had a season ticket to the New York City Ballet for as long as anyone can remember. Jefferson is within walking distance of their home, and walking and swimming almost daily in the TJU pool are his primary forms of exercise. Dr. Israel has travelled extensively from Japan to South America to Afghanistan; he estimates that he has been around the world three times.

In addition to his many other responsibilities, Dr. Israel has always been a consultant to the Valley Forge, Coatesville and Wilmington V.A. Hospitals. He has also unfailingly accepted invitations to speak in small towns, remote and unglamorous places that have no personal travel benefits attached. Though this is hardly common practice, especially for an Honorary Professor, Dr. Israel maintains that he receives the greater benefit. “It is the best way,” he says “to continue my education.”
1918
Dr. James L. Fisher, 224 N. Phelps St., Youngstown, Oh., writes that he is 81 years old and "still live with that lovely person I met in Philadelphia in my freshman year. We have 12 grandchildren and two great-grandchildren. I go to the office four days a week and usually have one or two patients in the hospital where I have been promoted (?) from Consultant to Emeritus. I would like to do it all over. And better."

1919
Dr. Harold K. Doranz, 325 W. Upper Ferry Rd., F5, Trenton, N.J., semi-retired, is now the Medical Director of the Parkway Nursing Home in Trenton.

1920
Dr. Louis F. Burkley, Jr., 452 W. Berwick St., Easton, Pa., retired in 1971 from an active Ob practice. "Taking it easy since my coronary in July, 1972, which has curtailed many of my activities, and friend wife, Edith, keeps a close eye on such."

Dr. William N. Lober, 940 Fairview Ave., Ephrata, Pa., has retired after 52 years of practice in Reamstown, Pennsylvania.

1921
Dr. Lawrence G. Heins, R.R. 5, Abilene, Ks., is County Commissioner for Dickenson County and has been for eight years. He retired from his practice in September, 1976.

1927
Fiftieth reunion plans have been finalized and Chairman James E. Bowman hopes that 100% of the class will be present. In addition to traditional activities (see calendar) there will be a dinner at the College of Physicians on South 22nd Street on June 8 and a luncheon the following afternoon at Jefferson Alumni Hall. The Alumni Banquet Thursday night will pay special tribute to all those present.

Dr. Arthur A. Fischl, 3071-29 St., Long Island City, N.Y., is a semi-retired consultant in medicine and a consultant and inpatient specialist in cardiology for the New York State Workman’s Compensation Board.

1929
Dr. Karl W. Hahn, 521 Linden St., Bethlehem, Pa., writes "I am still in the 'saddle' but do not ride as far and as fast as I did. Often look in The Clinic and think of the wonderful friends and years at Jefferson. Best wishes to all."

The Beauchamps... a Jefferson Family
Dr. Eugene W. Beauchamp of Chicopee, Massachusetts heads the Jefferson family tree which began with his graduation in 1923 (seated with Mrs. Beauchamp). Although he retired from his surgical practice in 1972 he still sees patients by appointment in his office. His four sons, whose years of graduation are as widely ranged as their specialities, are (from left) Joseph O., 1964, David T., 1959, Charles J., 1954 and Eugene, Jr., 1950. Dr. Joseph is an ophthalmologist with a practice in Naples, Florida; Dr. David, an obstetrician/gynecologist, resides in northern New Jersey; Dr. Charles is Chief of outpatient pediatric services at the University of California at Davis; and Dr. Eugene, who has been associated with his father since 1958 is Senior Surgeon at Mercy Hospital and Surgeon in Chief at Holyoke Veterans Hospital in Western Massachusetts. It is the single family boasting five practicing physicians from Jefferson. The youngest in the Beauchamp family is Denise Archambault, center.
1932

Reunion Chairman Nathan Schlezinger announces dinner plans for June 8 to celebrate the 45th class anniversary. Following daytime activities members will meet at the Locust Club for gourmet dining. Dr. and Mrs. George J. Willauer again will be special guests. Golf and other activities will be available Thursday prior to the Banquet.

Dr. C. Earl Albrecht, Box 38, Wirtz, Va., received the Meritorious Service Award from the Alaska Public Health Association. He served Alaska from 1935 and was Alaska’s first full time Commissioner of Health, in which post he served for 11 years. He was President of the Alaska Public Health Association and directed the Alaska Health Manpower Corporation, in addition to maintaining a private practice. Dr. Albrecht is the first recipient of the award. He is Honorary Professor of Community Health and Preventive Medicine at Jefferson.

1933

Dr. Dudley P. Bell, 155 Requa Rd., Redmond, Ca., writes “Fresh out of coronary which occurred in Europe this spring and summer. I have lost 35 pounds of dimpled loveliness and now feel fine.”

Dr. C. Perry Cleaver, 250 Main St., Catawissa, Pa., retired in 1975. “My last patient had also been my first patient in 1941. On March 29, 1976 I was given a surprise (and it was!) dinner at the Numidia Grange Hall, attended by 200 of my former patients and many of the children I delivered, and was presented with a gold watch engraved ‘from your grateful patients and friends.’”

1934

Dr. Joe Henry Coley, 401 N.W. 14th St., Oklahoma City, has been named Emeritus Professor of Obstetrics and Gynecology at the University of Oklahoma School of Medicine. Dr. Coley presently is serving as an Alumni Trustee at Jefferson.

Dr. John F. Keithan, 616 Sherwood Dr., Carlisle, Pa., discontinued his private practice a year ago in July, and presently is full time at the Dunhan Army Health Clinic in Carlisle.

1936

Dr. George L. Erdman, 2127 Lagoon Dr., Dunedin, Fl., has retired and recently took a trip around the world. Classmate Dr. Mark Hanna is his neighbor.

Dr. Paul E. McFarland, 5302 E. Palo Verde Dr., Scottsdale, Az., is practicing ophthalmology and recently took a partner, Stanley Shorb ’66.

Dr. Martin L. Tracey, 3810 Poinciana Dr., Lake Worth, Fl., is practicing at the Lake Worth Medical Center in internal medicine and gastroenterology.

1937

The 40th reunion for the class of ’37 again will be held at the Barclay Hotel, this year June 8. Dr. John J. O’Keefe, Chairman, notes that Leroy Bostic will be on hand to provide the music for the dinner dance.

Dr. Milton H. Gordon, Civil Aviation Administration, Ben Gurion International Airport, Israel, was Chairman of a Scientific Session at the International Congress of Aviation and Space Medicine.

Dr. Densmore Thomas, 2084 Atlantic, N.E., Warren, Oh., writes that Dr. and Mrs. Cee T. Swift of Belmont, California, were his guests at the Stanford-Michigan football game in Ann Arbor last September.

1939

Dr. Henry A. Shenkin has been appointed Professor of Neurosurgery and Head of Section at the Medical College of Pennsylvania. Previously an Associate Professor at the University of Pennsylvania, he also is Director of the Department of Neurosurgery and head of the residency program at Episcopal Hospital.

1940

Dr. Thomas B. Mervine, Red Bank Ave., Woodbury, N.J., presently is serving as President of the Gloucester County Medical Society. His term is for one year.

Dr. William H. Robinson, III, 4805 West Hills Dr., Topeka, Ks., has retired after 22 years of psychiatric practice at the Menninger Foundation. “In good health and hope to enjoy the quiet life for some time to come.”

1942

Chairman J. Wallace Davis has made plans for a dinner at the Faculty Club of Jefferson Alumni Hall on Wednesday evening June 8. Following the class’ private party members are invited to join with the 25th and 20th reunions for dancing downstairs. A class cocktail party will precede the Alumni Banquet June 9.

Dr. Joseph Rupp was recently given an honorary staff membership at the Conemaugh Valley Memorial Hospital, for his many years of involvement with continuing education programs in endocrinology at Memorial. Dr. Rupp is Professor of Medicine at Jefferson.

1944J

Dr. Robert A. McLemore, 1815 Crescent Dr., Springfield, Oh., writes that his son, William, is now a freshman at Jefferson.

1945

Dr. Stephen F. Balshi, 3354 Green Meadow Ct., Bethlehem, Pa., writes that his son Jim, a freshman at Jefferson, is meeting his classmates’ sons. “Daughter Kathy Balshi Kucer ’76 is internning at Bryn Mawr Hospital. Her husband Frank Kucer ’73 is completing his residency in internal medicine at Lanarku—a Jefferson family, all the way.”

Dr. John S. Madara, 31 Market St., Salem, N.J., writes that he is enjoying being President of the Medical Society of New Jersey and Regional Delegate to the American Hospital Association.

1946

Dr. Louis F. LaNoce, 5817 Henry Ave., Philadelphia, is President of the Medical Staff of Roxborough Memorial Hospital. His daughter, Virginia, graduated from Jefferson’s baccalaureate nursing school last June.

1947

The 30th reunion will take place the evening of June 8 at the Merion Cricket Club in suburban Haverford. Plans are being coordinated by Reunion Chairmen John J. Dowling and Elmer H. Funk. Transportation, of course, is being arranged.

Dr. W. Clayton Davis has been named Chairman of the Department of Surgery at York Hospital. Prior to this he was a Professor of Surgery at the University of Nebraska College of Medicine and Chief of Surgery at the V.A. Hospital in Omaha.

Dr. Edward A. Kelly, State Rd. and Addingham Ave., Drexel Hill, Pa. writes that his son, Edward ’73 opened a family practice office in Downingtown after finishing his residency at the Wilmington Medical Center.

Dr. Richard G. Kirchner, 23 Duke St., New Brunswick, N.J., writes that he built and occupies a new office building for the private practice of radiology and is very satisfied.

Dr. Gail G. L. Li, 2351 E. Manoa Rd., Honolulu, writes, “I will definitely be there, June 8, 1977. Daughter Gail Li Ma is a junior at Jefferson.”
Personal Qualities Can’t Be Quantified

Dr. Conly: What it comes down to in many cases is our perception of the student's personal qualities.

Here’s a story for you from Dr. Samuel S. Conly Jr., ’54 Associate Dean and Director of Admissions at Jefferson Medical College. “We were interviewing prospective first-year medical students, and I have this boy with an outstanding record from a fine school. On paper he looks like one of the best we’ll see. I hardly can wait to meet him.

“Well, he walks in and he’s wearing a T-shirt, dirty jeans, sneakers and sweatsocks. We talk and we really hit it off. I really like the boy. Finally I ask: ‘Why in the hell did you show up for your interview looking like that?’

“And he says: ‘I was afraid you might accept me because of my record.’ And I ask him: ‘What’s the matter, don’t you want to be a doctor?’ And he says: ‘No, I want to be a lawyer. My father wants me to be a doctor.’

“So I ask him why he didn’t iron this out earlier with his father and he says: ‘You don’t know my father.’”

Dr. Conly, who has a faculty appointment in physiology and who has been on the staff at Jefferson since 1950, says he tells that story to point up the importance of the personal interview in determining which of the 5,000 students who apply annually will be invited to fill the 223 first-year places at Jefferson, which since 1824 has educated more physicians than any other medical school in the country, more than 22,000.

“We get so many applications from students with excellent academic credentials. What it comes down to in many cases is our perception of the student’s personal qualities.

“Sometimes, as in this story, it’s an easy matter. Other times it’s very difficult because there’s no way I know of to quantify personal qualities, in the way we do grade averages and test scores.

“There are far more acceptable students than we have places for. Most applicants, if admitted, would make it through. That’s the damnable part of it. I’m sure some well-qualified students won’t make it into any U.S. medical school.”

From the 5,000 students who apply each year at Jefferson, admissions committee members invite 1,000 for personal interviews and send rejections to the 4,000 others.

This weeding-out process is based on an evaluation of the student’s application, his undergraduate grades, his letters of recommendation and his scores on the Medical College Admission Test.

Dr. Conly: “There’s a place on the application for the student’s personal comments. This is our first big clue to what he’s like as a person. As nature abhors a vacuum, I abhor a blank page. It’s not so much what the student says but the way he says it.

“On one application the student had pasted a picture of a guru with yellow lines radiating out. Then he had cut out big yel-
low letters from a magazine and pasted them at the bottom. They read: 'Light is life; all life is light.'

"Well, hell, if that guy isn't sick, at least he's shown poor judgment, and, God knows, doctors need good judgment."

The applicant was not one of the 1,000 invited for personal interviews, Dr. Conly says.

After an interview a prospective student's file goes before the 26-member admissions committee, which meets two hours a week for 40 weeks around a 4-by-19-foot table and decides who will be offered admission.

Dr. Conly: "Nationally, the odds of being admitted are 1 in 3—or 1 in 2 if the applicant is from a minority race."

Q. You say personal qualities are very important in a medical school student. What qualities are you looking for?

A. That's what makes this business so difficult. If we had only one end product—say, the family physician—then we could isolate those qualities that we think the family physician needs. But we're turning out not only family physicians but also pathologists and surgeons and many other specialists.

In family medicine, compassion obviously would be a highly valued quality. It's less important for a pathologist, who deals with cadavers. But in general the qualities we seek for all doctors would include integrity, strong motivation to medicine, emotional maturity, tolerance, sensitivity and the ability to communicate.

We try to get a line on these qualities during the interview, which runs from 30 minutes to an hour—in a one-to-one situation, the prospective student and a member of the admissions committee.

Q. How do you try to determine a student's motivation to be a doctor?

A. I like to ask: "What will you do if you don't make it into any medical school this year?" If, without hesitation, the student answers: "Why, I'd study to be an architect," well, then I'd wonder about his motivation toward medicine. What we're looking for is somebody who'll tell us he'll continue to try, perhaps go to a foreign school if he can't make it in the U.S., or perhaps go into some health-related field.

With any applicant we ask ourselves: "Can he get through medical school?"

We have good reason to have high confidence in a student's undergraduate academic record, since repeated studies have shown a positive correlation between scholastic average and successful completion of medical school. It would be difficult to defend the admission of a student with low or mediocre grades and the denial of a place to a student with superior grades—other factors being equal.

But again I must stress: Personal qualities are every bit as important as grades. When we decide who'll make it and who won't, we give 50 percent weight to these personal qualities.

Q. Do most students who are admitted graduate? What's the dropout rate?

A. Nationally the dropout rate is about four percent. Here at Jefferson it's about two percent. And we're working to lower that.

Q. You said a minority-race student's chances of being accepted into a medical school are better than a nonminority student's chances. Are standards lowered for minority students?

A. All medical schools are making an effort to encourage better representation of students from diverse racial and socio-economic backgrounds, to provide increased opportunity for underrepresented groups in medicine. The same standards apply to every medical student once he's admitted.

Q. What about before admission?

A. We look at grades and whether he'll be competitive, but we also look at his personal qualities and his motivation and his chances of making it through school.

Q. What would your advice be to somebody still in high school who'd like to become a doctor?

A. In high school make damn sure your performance is at a high level so you can be selective in the college you attend. It's important where you go to undergraduate school—since some are better than others. Our admissions committee takes this into consideration. An "A" from one school would carry more weight with us than an "A" from another school.

Q. What about the aspiring doctor after he gets to college?

A. Continue to perform at high level and get involved in extracurricular activities that broaden your experience and expose you to other people. We look favorably on extracurricular involvement up to the point where it detracts from grades. Then it becomes a negative factor.

But if we found a straight-A student who scored high on his medical tests and who played football, say, we'd go out and put a rope around him. We don't see too many like that.

Also it's helpful if the student has some direct exposure to medicine—such as working as a volunteer in a hospital emergency room. This says something to us about his motivation, that his interest in medicine is not strictly romantic.

Q. Is it possible for somebody who's not qualified to practice medicine to be graduated from a medical school?

A. Not from here. No, I just don't see how that's possible from any medical school—because students are tested so thoroughly for their competence in knowledge not only in academics but also in clinical work, where their contact with patients is closely observed. We once flunked out a senior who wasn't able to relate to his patients.

Some doctors will be better than others—as in any field. But, no, there shouldn't be any unqualified doctors.

1948

Dr. Millard N. Croll, P.O. Box 180, St. Davids, Pa., is a co-editor of Nuclear Ophthalmology, recently published by John Wiley & Sons.

Dr. Robert K. Finley, Jr., 31 Wyoming St., Dayton, Oh., has been appointed Clinical Professor of Surgery at Wright State University School of Medicine.

1949

Dr. Arthur E. Orllidge, Box 98, Shanksville, Pa., is Acting Superintendent of Hollidaysburg State Hospital. He will continue as Superintendent of Somerset State Hospital as well, where he has served since 1961.

Dr. Edward Schauer has been appointed Director of Family Practice at Jersey Shore Medical Center in Neptune. He has been on the Center's staff for 24 years.

Dr. Jack R. Woodside, 9125 Christopher St., Fairfax, Va., recently spent five weeks as a registered lobbyist representing the Medical Society of Virginia in its efforts to influence passage of malpractice legislation.

1951

Dr. William E. Wallace, 1851 Arlington St., Sarasota, Fl., has a busy neurological practice. He has also formed the W. E. Wallace Corporation to manufacture, market and sell products of his own invention; he has six inventions in the last 10 years, four of which are patented, two patent pending. His inventions have included a unique type of oxygen tent, a magnetic closure for caskets, and a disposable, inflatable bedpan. He is also writing a novel and a book of poems.

1952

The big 25th! Scheduled for June 8, the party will get under way with cocktails in
rived, and a reorganization of the department and its educational programs had already been started. Thus we could assure the LCME in the progress report that their concerns in this area are being corrected.

Reservations were expressed about matters in a number of other departments including the Department of Community Health and Preventive Medicine which is now undergoing a special review, the Departments of Radiology and General Surgery which have just been reviewed by committees of the faculty, and the Department of Neurology which was surveyed by our own committee in 1973. This review of Neurology was very thorough and extended over a period of several months. The conclusions did not agree with those of the LCME visitors.

The surveyors felt that the student affairs program at Jefferson was not adequate for our large student body. In the progress report the LCME was informed that the student affairs program has been strengthened considerably since the survey visit. There are now two Associate Deans for student affairs, one of them mainly for the minority program, and also a full-time Director for Student Health. All students are assigned faculty advisors at the time of matriculation. The faculty is aware that the administration of a student affairs program in a medical school of this size is a challenge, and excellent rapport exists between the student body and the faculty and between the students and the administration.

Specific concern was raised about the Jefferson-Penn State accelerated program, and it was suggested that the pressures of this program may cause extraordinary emotional problems in these students.

The Jefferson-Penn State accelerated program is one of the oldest in the United States. Established in 1963, it has been studied more extensively than almost any other accelerated program. Nevertheless, an ad hoc committee was charged to make another review of the entire 12-year experience of the Jefferson-Penn State program. After careful consideration of all aspects of this accelerated program, the faculty committee recommended that it be continued but that the number of matriculants be held at the current level. This conclusion was based on the unique opportunity which the program has provided to selected students to pursue an alternative pathway to a medical career; to the success and popularity of the program; to the additional years of medical practice which the public receives (3 years/graduate); and to the fine relationship which the program has created between Jefferson and Penn State University.

The final reservation of the surveyors pertained to the relationship between the Medical School and the Thomas Jefferson University Hospital, and particularly to the fiscal implications upon medical education of the development of a large new hospital facility. The progress report states that the hospital is financed separately from the medical school and that its operating budget and endowment are accounted for separately. While the intimacy of the hospital and the medical school requires an exchange of funds for various services, every effort is made to maintain the fiscal integrity of each division. The successful completion of the bond issue and the extensive fiscal analysis which preceded it have demonstrated the University's ability to construct a new hospital and to keep its fiscal integrity separate from that of the medical school.

This completes the matters which were covered by the LCME progress report. Each one will be reassessed at the time of the next survey in 1978.

Attention should be directed to the expansion of our research activity in the past several years. Although sponsored programs as a whole have shown a decrease, federally sponsored research has grown from $4,122,519 in 1973-1974 to $5,796,994 in 1975-1976. (Federally sponsored contracts showed a decrease last year because funds for the breast screening program were listed in total in the previous report of last year.) There also was nearly a one and a half million dollar decrease in administration awards reflected by the drop in the capitation grant and a loss of the entire special project grant for physician augmentation. These losses were experienced by all medical schools because they represented a change in federal policy toward support of medical education.

The operating budget figures are grim. Although operating income will not change appreciably from last year, expenses continue to mount and so the operating deficit will exceed our ability to cover it with recurring sources of other income by more than two million dollars. This will be a serious handicap to the medical school when we begin to develop a new budget for next year. With this is mind the Trustees have approved another tuition increase to $6,000 for the freshman class of 1977.

Academically, the state of the medical school was strong at the close of fiscal 1976. The faculty can be proud of the continued improvement of our teaching and research programs. Fiscally, we have serious problems, and our only solace in this area comes from looking about us and finding ourselves in such distinguished company.

the garden court of Jefferson Alumni Hall with dinner and dancing following. Chairman James E. Clark is looking for the largest turnout ever, hopefully 100 of the 152 members.

Dr. Robert V. Finnesey has been appointed to the medical staff of Jersey Shore Medical Center in Neptune, New Jersey. He is serving in the Department of Orthopaedics. An Associate Professor of Orthopaedic Surgery at the New Jersey College of Medicine, he also is President-elect of the medical staff at the Orange Hospital Center.

Dr. Bernard W. D. Fong, 97 Dowsett Ave., Honolulu, has been appointed to the National Heart, Lung and Blood Advisory Council of the National Heart, Lung and Blood Institute. Dr. Fong is a Governor of the American College of Physicians, Past President of the Hawaii Heart Association and a member of the American College of Cardiology. He has served as Associate Clinical Professor of Medicine at the University of Hawaii.

Dr. George T. Wolf is Director of Family Practice Residency Program at the Moses H. Cone Memorial Hospital in Greensboro, North Carolina. He is also an Assistant Professor of Family Medicine at UNC-Chapel Hill.

1953

Dr. Franz Goldstein, 707 Arlington Rd., Narberth, Pa., recently served as Program Chairman of a three-day postgraduate course in Montreal, organized by the American College of Gastroenterology. He remains a member of the College's Board of Trustees and Chairman of its Committee on Postgraduate Courses.

1954

Dr. Harold J. Reinhard, Box 240, Warren, Pa., had two daughters marry this past summer. He has been appointed to the Board of Directors of the Warren Division of Pennbank.

Dr. Joseph W. Simpson, 2391 Hickory Rd., Plymouth Meeting, Pa., is the Director of Medical Services for the Consolidated Rail Corporation. He is enjoying the position in fine health and is looking forward to the class' 25th reunion in 1978.
Dr. Edwin D. Arshit, 3909 State Rd., Upper Darby, Pa., has been named Director of Medical Education at Delaware County Memorial Hospital. He is also Director of the Employee Health Clinic and the Allergy Clinic there. A Diplomate of the American Board of Family Practice, he is a Clinical Instructor in Family Medicine and in Community Health and Preventive Medicine at Jefferson.

Dr. Merlyn R. Demmy, 16 Club House Dr., Bernville, Pa., has a full-time private practice of general psychiatry in Reading.

Chairmen John Prehatny and William Rutter have made plans to share Jefferson Alumni Hall with the 25th reunion class on Wednesday evening June 8: cocktails, dinner and dancing for the 20th anniversary party.

Dr. Walter Spelsberg Tilghman, 1200 Harrison Ave., Elkins, W. Va., would welcome inquiries from classmates who might be interested in relocating their practices to the Memorial General Hospital in Elkins. He recently relocated his practice of ophthalmology there following a move from southern California. "I arrived in Elkins and saw the beautiful hills of West Virginia and realized the great need of the people and the potential of the Hospital and Clinic. It should become an outstanding medical center for the entire area."

Dr. Ronald E. Traum, 415 Silverhill Rd., Cherry Hill, N.J., is an Associate Professor of Obstetrics and Gynecology at Jefferson. He is practicing and teaching reproductive endocrinology and infertility.

Dr. William F. Wolfe, 2914 Sunset Dr., Camp Hill, Pa., is practicing general surgery with two other general surgeons. He is affiliated with Hershey Medical School, Holy Spirit and Seidle Memorial Hospital. He is married and has five children.

Dr. John T. Antolik, 19 W. Maiden La., Somerdale, N.J., writes that he and his wife had their fourth child, Christian Cyril, on January 14, 1975.

Dr. Richard E. Eshbach, 889 Cressman Rd., Harleysville, Pa., plans to work and study at the University of Athens, Greece, in 1977.

Dr. George A. Griggs, 11 Sonata Tr., Little Rock, Ark., retired in November from the U.S.A.F. He has joined the full-time faculty of the University of Arkansas Medical School as an Assistant Professor of Medicine working in the Little Rock V.A. Hospital in pulmonary diseases.

Dr. David J. Jones, III, 1455 Virginia Ave., York, Pa., has been named Vice-President-Utilization for Pennsylvania Blue Shield. Dr. Jones has been a member of the staff of York Hospital since 1974 where he was Director of Patient Care Review, Associate Director of Medical Education and Coordinator of Community Medicine. He is also an Associate Professor of Medicine at the University of Maryland School of Medicine in Baltimore.

Dr. Gino Mori, Scranton UFE Bldg., Scranton, Pa., writes that he just added Terence A. Cochran, who did his residency at Jefferson, to his general surgery practice.

Dr. James M. Stern, Rt. 5, Box 164 C, Waynesboro, Pa., spent nine years as a medical missionary in Rhodesia, then took a surgical residency at the University of Buffalo and University of Miami. He has been practicing general surgery in Waynesboro since 1973, with two other surgeons. This past summer his family spent four weeks working at a mission hospital in Zambia.

Dr. Thomas C. Peters, 4701 N. Federal Hwy., Ft. Lauderdale, FL, has been listed in the Marquis 1976-77 "Who's Who in America for the South and Southwest." A family physician, he is on the staff of four hospitals. He has published many articles on cardiovascular research and is Vice-President of the International Doctor's Club. He and his wife, Effie, have one daughter, Helene Denise.

Dr. Joel R. Temple, 519 N. Pennsylvania Ave., Dover, Del., announces the birth of twin girls, Laura and Rachel, in October, 1976.

Dr. Steven R. Homel, 222 Rittenhouse Sq., Philadelphia, is Medical Director of the Federal Reserve Bank of Philadelphia, a consultant in health education and human behavior and Instructor in adolescent medicine at Jefferson. He has served on many committees, including the President's Committee on Health Education.

Dr. Howard A. Platt has become associated with Northeastern Neurological Associates, Scranton Life Building, Spruce Street, Scranton, Pennsylvania. He had been engaged in private practice in Lebanon previously and is on the staffs of Community Medical Center, Mercy Moses Taylor and Scranton State General Hospitals. He and his wife, Vera, have three children.

Dr. William B. Pratt, 1116 Wagonwheel, S.E., Albuquerque, N.M., is on the staff of the orthopaedic department at the University of New Mexico School of Medicine as an Assistant Professor.

The 15th reunion for '62 is being planned by Chairmen Steve Gosin and Jerry Venville. Date for the class function is Wednesday, June 8 at a place to be announced. The traditional program of clinics and Dean's Luncheon will take place earlier that day. More to come by mails in early '77.

Dr. Norman F. Fisher, 25 N. 14th St., San Jose, Ca., resides in Monte Sereno with his wife, Judy, and their three children. He practices pediatric ophthalmology and is also a Research Associate at the Institute of Visual Sciences in San Francisco and a Clinical Associate Professor at Stanford, where he has directed the Ocular Motility Clinic for nine years. "Should any alumni be in the area, please contact us."

Dr. Henry Gelband, 15020 S.W. 69 Ct., Miami, was appointed Director of Pediatric Cardiology at the University of Miami School of Medicine. He was awarded a research grant from the March of Dimes to continue studies in cardiac arrhythmias associated with congenital heart disease.

Dr. Dale C. Brentlinger, 155 S. Madison St., Denver, is President of the Colorado Society of Internal Medicine for 1976-77.

Dr. George H. Cohen, 1350 Brandt Rd., Hillsborough, Ca., is a Board certified cardiologist. He has a private consultative practice and is involved in the cardiac catheterization laboratory of the Peninsula Hospital, of which he is a member of the Executive Committee. He and his wife, Elaine, have two sons and a daughter.

Dr. Joseph C. Flanagan, 1627 Lafayette Rd., Gladwyne, Pa., is first Vice-President of the Pennsylvania Academy of Ophthalmology and Otolaryngology.

Dr. Wilfred T. Morioka, 1432 Sandal La., La Jolla, Ca., is Chairman of the Department of Otolaryngology at the Naval Regional Medical Center in San Diego.

Dr. John M. Donnelly, II, has been appointed Chairman of the Accreditation Committee of the Institute of Pennsylvania Hospital, Philadelphia. He also maintains a private psychiatric practice, and resides at 200 Wister Rd., Ardmore.

Dr. Donald F. Eipper, 2051 Ridgewood Rd., Akron, Oh., writes that he and his wife,
The artificial kidney developed at Jefferson and at the Crozer-Chester Medical Center in 1967-68 by Dr. James E. Clark is now being used in the Soviet Union. Consequently when the Soviet Ministry of Health decided to sponsor a symposium featuring American nephrologists they chose Dr. Clark '52 to organize and moderate it. The Soviets found Dr. Clark through the Brussels company that manufactures his artificial kidney, Extra Corporeal Medical Specialties, Inc. A Russian physician, Dr. Thaker, met with Dr. Clark at his offices at Crozer-Chester to explain the proposed nature of the symposium and to invite Dr. Clark, on behalf of the Ministry of Health, the Committee on Science and Technology and the Chamber of Commerce of the U.S.S.R. to select several other nephrologists to accompany him and to plan an agenda. The symposium was conceived as a prelude to the 25th Congress of the Communist Party, to help give direction to the design of hospital dialysis units for the next five-year plan.

Rather than choose Philadelphia area colleagues to participate, Dr. Clark, who is Chairman of the Department of Medicine and Chief of Nephrology at Crozer-Chester, decided to assemble a group representing all parts of the country. A natural choice was Dr. Lewis W. Bluemle, President of the University of Oregon Health Sciences Center, with whom he had collaborated on the artificial kidney. The rest of the group included Dr. Wadi N. Suki, Chief of the Renal Section and Professor of Medicine at Baylor School of Medicine and Dr. George P. Baker, Jr., Director of the Dialysis Unit at Massachusetts General Hospital.

Although the original concept had been a one-day symposium, the Soviets and Americans agreed via Telex communications that there was enough material to extend it to three days and to include Russian scientists in the presentations. It was arranged that each participant would give two lengthy papers, and slides were prepared in Cyrillic and English.

The trip extended from January 31 to February 15, 1976. When the physicians and their wives first arrived in Moscow they were met formally at the airport by a Soviet delegation including physicians and representatives from the Ministry of Health. The delegation presented them with flowers and gifts, and they were waved through Customs to a private bus which took them to

Dr. Clark (left) at Crozer Chester Medical Center with Visiting Russian Professor Valeriy I. Shumakov
the Intourist Hotel. Expenses for the entire trip for both physicians and their wives were shared by the Soviet Union and Extra Corporeal Medical Specialties.

The conference was held in the Second Medical Institute Building, an old structure, where, at least, no one fell asleep during the proceedings: the room temperature was only 40°. Terming it an old structure, it should be noted, is no capitalistic slur. The hospital of the Institute was the same one in which Napoléon was treated for gonorrhea in the early 1800s. Because Dr. Clark's was the first American group ever to discuss kidney disease in the Soviet Union and because the conference was the first ever on dialysis, it was very well attended by 150 physicians from all over the U.S.S.R. There was simultaneous Russian/English translation by excellent interpreters and active audience participation throughout.

Non-conference days were spent for the most part touring various medical schools and institutes. Physically, Dr. Clark says, touring most of the buildings was like touring Philadelphia General. The beds were white iron, wards were common, and no apologies were made for the aging facilities. Although Dr. Clark found their surgical technique to be excellent, he was surprised that visitors in street clothes were allowed en masse into the operating rooms, and OR personnel wore no protective covering over their shoes.

Soviet dialysis equipment is old, usually Western-made and primitive by U.S. standards. "They are easily about 15 years behind Western Europe and the U.S. in this regard," Dr. Clark reports. "In nephrology and in other specialties they seem unfamiliar with disposable equipment. They still even launder bandages. The modes of treatment for kidney disease are comparably outdated. They pay little attention to bone disease, anemia, hepatitis, or high blood pressure as they relate to kidney problems, and they use no arteriovenous shunts because the incidence of clotting and infection has been so high."

Only about 500 people in the entire Soviet Union are on kidney dialysis, as compared with approximately 30 thousand in this country. Although the Transplantation Institute in Moscow does 150 transplants a year, more than a comparable American institution would do, in Leningrad, a city the size of Chicago, their first transplant was done only recently and only eight people are being treated by dialysis. Such figures might suggest regionalization, but this is far from the case. When Dr. Clark asked, for example, which transplantation institute, given several in the vicinity of an organ donor's hospital, would receive the organ, the reply was simple: "Whichever were quickest."

Research in the Soviet Union seemed to Dr. Clark rather less methodical than in the United States. One institute the group visited, for example, was working with hyperbaric chambers in many seemingly unrelated ways. They were very proud that the first obstetrical delivery ever done in a hyperbaric chamber had recently occurred there, but there seemed to be no point to the experiment beyond the achievement of a "first." In the same anecdotal vein, they spoke of planning the first transplant done in a hyperbaric chamber. "There were no particular expectations or experimental goals. They were just going to see what happened," says Dr. Clark.

One aspect of medical care the group was not permitted to see was the Kreml Clinics, the private hospitals for the privileged ten percent, prominent party members and others of the upper caste. The Soviet physicians acknowledged the existence of the Clinics, but refused to discuss them. "It was easy to assume, however, that these facilities were kept secret because they were superior to those we saw."

The American visitors were shown every courtesy throughout their stay, and it was clear their hosts wanted the trip to be personally enjoyable. Dinner at the hotel on the Americans' first evening in Moscow, for example, set the pattern for the alcoholic day and night receptions to follow. The well-known Russian custom of the toast was very definitely observed, with the rule being that once a bottle, usually of vodka or cognac, was opened it must be finished. During a typical day, the visitors participated in three toast-filled receptions, one in mid-morning and one at 4 P.M. at whichever institute they happened to be, and an elaborate formal hotel dinner in the evening. Entrées at dinner were usually chicken or fish, but two foods appeared at all times of day: caviar and open-faced sturgeon sandwiches.

"Sturgeon," Dr. Clark notes, "is a very fatty fish, and a very pungent one. After three days in Moscow I seemed to smell sturgeon wherever I went. Then I realized it was my own skin that smelled like sturgeon fat. I stopped eating it, but soon realized why it's so popular there. Without that sturgeon fat to absorb some of the alcohol, the toasts can completely do you in."

Dr. Clark was struck by the intricate protocol of the toasts and the seating arrangements at formal receptions, and by the total absence of the artful flower arrangements that adorn banquet tables in this country. "There were flowers," he says, "but they were just stuck haphazardly in the vases." Many gifts and tokens were exchanged with great ceremony at these affairs, including presentations by the Americans of handsome medals donated by the Franklin Mint, of which Dr. Clark is Medical Director. The Soviets were particularly fond of lapel buttons as gifts, bearing historic or political messages.

Protocol notwithstanding, the toasts came progressively friendlier and less formal as the Soviets and Americans got to know each other better. And, Dr. Clark notes, the Soviets were eager to prove that they and their way of life were not what the American stereotype portrays. "They seemed to feel that they had many of the same misconceptions about America as we had about the U.S.S.R. Toward the end of our stay the toasts all conveyed the same message: may our two countries always be at peace."

The Soviets had planned an active schedule for their guests, including attending the Bolshoi Ballet, the opera or some cultural event nearly every evening. One of the highlights of the visit was a tour of Zagorsk, the only Russian Orthodox seminary still in existence in the U.S.S.R. The guest book which they were asked to sign indicated that Zagorsk is a popular place to bring dignitaries, since the only names Dr. Clark recognized were those of U.S. astronauts. Interestingly, Dr. Clark reports that the Soviet physicians seemed equally fascinated and clearly had not been to Zagorsok before. "They asked as many questions as we did," he says.

The American physicians also visited Leningrad during their stay, transported via the Red Arrow Express, a train much more reminiscent of Hollywood than Amtrak. Replete with tapestries and gilt-appointed private compartments, "It was like the Orient Express. Everything was spotless and attention given the smallest detail. Tea, for instance, was served from a giant ornate samovar in polished silver filigree cups."

The exact timing of the eight-hour trip was no less amazing to those accustomed to U.S. rails: the Arrow left Moscow precisely at midnight and pulled into Leningrad on the stroke of eight.

The physicians' stay in Leningrad was made unforgettable by their day-long private tour of the Hermitage, including the Scythian Gold Rooms. The tour was arranged through a chance meeting with a group from the U.S. who were setting up an American exhibit at the museum. "The curator of the exhibit had had a kidney transplant, needed attention and was unable to get the names of any Russian nephrologists. Because he was grateful for our help, he arranged our private tour."

With the exception of the Kreml Clinics, the prevailing Soviet attitude throughout the tour was one of openness. Dr. Clark was free to take photos wherever he chose, and as their Soviet host laughingly explained, no permission was needed from patients or personnel. "We don't even need a patient's permission to do a transplant," he said. "And we have no malpractice insurance." The only hindrance, in fact, to Dr. Clark's photographic efforts was quite unrelated to Communist interference: at a temperature of 40° below zero, his camera froze.
Marily, had their first child, Françoise Renée, on July 29, 1976. He is the Director of Nephropathy and Hemodialysis at Akron General Medical Center. He is Chairman of the Division of Nephropathy at Northeastern Ohio University's College of Medicine.

Dr. Harvey A. Levin, 818 Milwaukee Ave., Dunedin, Fl., writes that he has been appointed Clinical Assistant Professor in the Department of Obstetrics and Gynecology at the University of South Florida Medical School.

1965

Dr. James L. Conrad, 601 N. 5th St., Perkasie, Pa., began a preceptorship program with Jefferson's Family Practice Department, taking fourth-year students for six-week field experience.

Dr. James E. Copeland, Jr., 65 Royal Palm Blvd., Vero Beach, Fl., is practicing ophthalmology. He has been re-elected President of the Indian River County Medical Society.

Dr. James R. Dingfelder, 2003 Fireside Dr., Chapel Hill, N.C., is an Assistant Professor of Ob-Gyn at the University of North Carolina. He and his wife, Karen, have three boys.

Dr. Nathan B. Hirsch, 507 Sevilla Ave., Coral Gables, Fl., is an Assistant Clinical Professor of Ob-Gyn at the University of Miami School of Medicine.

Dr. William H. Rogers, 175 E. Brown St., E. Stroudsburg, Pa., is certified by the American Board of Surgery. He is doing vascular and general surgery at Pocono Hospital.

Dr. Richard P. Wenzel, 1940 Fox Run Dr., Charleston, Sc., recently presented two papers on hospital infection control in Lund, Sweden. "Our ex-Chairman of Medicine, Bob Wise, was also on the trip." Dr. Wenzel is enjoying academic practice at the University of Virginia. He and his wife, Jo Gail, have a daughter, Amy, and a son, Richard.

1966

Dr. Lynn G. Cranmer, 1150 N. Ventura Rd., Oxnard, Ca., writes that he enjoyed attending the 10th reunion and seeing all the new construction.

Dr. Arthur B. Lintgen, 1245 Highland Ave., Abington, Pa., is a Board certified internist and Fellow of the American College of Physicians, presently practicing internal medicine at Abington Memorial Hospital and Holy Redeemer Hospital.

Dr. Nicholas J. Ruggiero has been elected Director of Cardiology at Wilkes-Barre General Hospital, where he did his internship. Dr. Ruggiero took his residency and a Fellowship in cardiology at Jefferson where he was a member of the faculty. Dr. Ruggiero will also serve as Director of the Cardiac Catheterization Laboratory.

Dr. Walter F. Weis, Jr., 134 Parkwood Dr., Wilmington, N.C., has a private practice of orthopaedic surgery in Wilmington. He has three daughters and a son.

1967

Chairman Tony Padula announces plans for the 10th reunion on Saturday June 11. The classes of '67 and '72 will share the facilities for a dinner dance that evening at Jefferson Alumni Hall. Plan to attend.

Dr. Robert G. Little, Jr., 4621 Tarryton Rd., Harrisburg, Pa., is enjoying four-man group family practice. He is on the Board of Dauphin County Drug and Alcohol Commission and the American Cancer Society. "Investigating psychiatric phenomena and after-death experience."

Dr. David L. Sall, 336 Prudential Dr., Ste. 232, Jacksonville, Fl., and his wife, Virginia, have a five-year-old son, Jacob. Dr. Sall is Board-certified and has a private psychiatric practice in Jacksonville.

Dr. Carl L. Stanitski, 200 Meyran Ave., Pittsburgh, was on campus in December for the meetings of the Jefferson Orthopaedic Society. "Am representing the non-graduate physicians on the Executive Committee of the University of Pittsburgh School of Medicine." Dr. Stanitski, 67's class agent, is also doing some fundraising for Pitt.

Dr. F. Ardell Thomas, 24 Walnut St., Westboro, Pa., has been appointed a Clinical Instructor in Family Medicine at Jefferson.

1968

Dr. Joel M. Barish, 1988 Calle Madrigal, La Jolla, Ca., passed his Board's in gastroenterology and is now in private practice in San Diego. His wife, Carole, practices part-time pediatrics. They have a son, Doug, age three.

Dr. Paul R. Bosanac, 2200 Hamilton St., Allentown, Pa., is practicing nephrology in partnership. A Board certified internist, Dr. Bosanac had been a major in the Army medical corps and later Director of the Renal Dialysis Unit at PGH. He was on the faculty of the University of Pittsburgh School of Medicine.

Dr. Barry Corson, English Village Professional Center, North Wales, Pa., has been appointed a Clinical Instructor in Family Medicine at Jefferson, Chestnut Hill affiliate.

Dr. Philip E. Donahue, 5201 S. Cornell Ave., Chicago, finished his residency in general surgery at the University of Illinois Hospital School of Medicine, University of Illinois in Chicago. He and his wife, Susan, had their firstborn, Laura Rose, on October 7, 1976.

Dr. Clifford A. Gordon, 1777 Hamburg Tpke., Wayne, N.J., added an associate to his practice and a son, Jeffrey, to his family, making two girls and a boy.

Dr. Lawrence V. Hofmann, 2901 Washington St., Vicksburg, Mi., and his wife had a baby girl last March. "All is going well with our work at the Children and Youth Clinic."

Dr. Robert A. Jacobs, 2615 N. Vermont Ave., Los Angeles, recently presented a paper at the First International Congress on Child Abuse and Neglect, held in Switzerland last September.

Dr. Joseph F. Kestner, 1400 Delaware Ave., Wilmington, De., has a pulmonary medicine practice there. He announces the birth of his first baby, Heather Mary.

Dr. Martina Mockaitis Martin, 17 Dartmouth Ln., Haverford, Pa., is practicing internal medicine and rheumatology in Bryn Mawr. She became a Fellow of the American College of Physicians in April, 1976.

Dr. Carl D. Metzger, 1123 Shore Rd., Cape Elizabeth, Me., is practicing child and adult psychiatry. He and his wife, Linda, have four children.

1969

Dr. Alexander C. Gellman, 57 Lake Shore Dr., Rockaway, N.J., is practicing urology in Denville, solo. His son, Billy, is three and one half and his daughter, Randy, is ten months. "Saw roommates Dave Katz and Mike Giniecki in Kansas City in January for our urology Boards—we all passed. Classmate Gene Timmins is practicing neurosurgery here now."

Dr. M. Dean Kinsey, 328 Newbold Ave., Moorestown, N.J., has been appointed an Assistant Professor of Medicine at Jefferson.

Dr. Alan I. Schein, 4471 Nantucket Rd., Harrisburg, is practicing ophthalmology with Dr. Warren Phillips '34 in Harrisburg. He and his wife, Caren, have two children, Jason, two and Ellen, six. Dr. Schein is also a Clinical Instructor at Temple University School of Medicine, where he did his residency.

Dr. Anthony S. Tornay, Jr. has been appointed to the staff of the Lahey Clinic in Boston. He took his internship and residency at Duke University Hospital and was a Fellow in gastroenterology there and a Fellow in the Liver Study Unit at Yale. He is a Diplomate of the American Board of Internal Medicine. He and his wife have two children.

1970

Dr. Joseph A. Comfort has been appointed to the Department of Anesthesiology at
Joseph L. Eastwick, center, was presented with the second Cornerstone Award at the dinner meeting of the President's Club members last fall. He was honored for his outstanding generosity, particularly through the establishment of the Joseph and Suzanne Eastwick Center in South Philadelphia, a facility which provides comprehensive medical care for entire families. Mr. Eastwick, who has been a member of the Jefferson Board since 1943, served as both President and Chairman of the Board of James Lees & Sons in Bridgeport, Pennsylvania. He has served on the Boards of numerous corporations and presently is a trustee at Ursinus College. Both Jefferson and Ursinus awarded him a Doctor of Laws degree. Mrs. Eastwick, right, also was cited for her many Jefferson interests. Dr. Hal E. Snedden '50 is at left.

The President's Club Dinner

The President's Club Dinner, an annual black tie affair, is given to recognize and thank those members whose contributions to Jefferson are in excess of $1,000 annually. From left for the 1976 event are Dr. Carl Zenz '49, who traveled from Milwaukee, Wisconsin, Dr. Paul A. Bowers '39, Dr. Dale W. Garber '24 and Dr. John H. Hodges '39.

Dr. and Mrs. Earl K. Sipes '46 of Allentown, Pennsylvania, left, are welcomed by Mrs. George J. Willauer. Dr. Willauer '23, who served as Chairman of the Thomas Jefferson University Founders Fund, shared hosting duties with President and Mrs. George M. Norwood, Jr., at the University's Jefferson Alumni Hall.
Dr. Rodney D. Dorand has opened a private practice in Brockton. He and his wife, Carole, enjoy the New England area.

Dr. Robert F. Johnson, 25 Place Rd., Falmouth, Ma., and his wife have a new little daughter, Sasha, born September 21, 1976. She joins her brother, Ivan, as their second child. He is in the private practice of family psychiatry at the Hallgarth Institute of Cape Cod.

Dr. Ronald A. Leff, 160 S. Georgia Ave., Mobile, Al., is now in group practice in anesthesiology after completing two years at Maxwell AFB.

Dr. John T. Martsof, 307-671 William Ave., Winnipeg, Manitoba, continues in a clinical genetics Fellowship. He and his wife and the new arrival to the family, Martin Philip, will return to the United States next year.

Dr. Larry S. Myers, 1779 Nacogdoches, #145, San Antonio, Tx., completed his psychiatry residency at Walter Reed Army Medical Center in June, 1976. He is now stationed at Brooke Army Medical Center, Fort Sam Houston, Texas.

Dr. John Reichel, III, 1060 Congress Valley Rd., Napa, Ca., started practice in the Napa and Sonoma wine country in Northern California. "Completed residency in plastic and reconstructive surgery at Stanford—finally!"

Dr. Roger L. Terry, 14 Suffolk Ct., Mt. Holly, N.J., completed his orthopaedic surgery residency at Fitzsimons—University of Colorado in June. He is now completing his military obligation at Walston Army Hospital, Fort Dix.

Dr. Neil O. Thompson, 3411 Guilford Ter., Baltimore, completed his general surgical residency at Union Memorial Hospital. He anticipates a fall, 1977 departure for Southeast Asia as a member of an overseas missionary fellowship.

Dr. Martin A. Tobey, 12721 Preston Rd., Dallas, announces the birth of his first son, Daniel Lee. He completed his army tour and is now a Fellow in Cardiology at the University of Texas Health Science Center in Dallas.

Dr. Calvin L. Weisberger, 538 11th St., Santa Monica, Ca., is practicing cardiology with Southern California Permanente Medical Group and is Assistant Clinical Professor of Medicine at U.S.C. He and his wife, Janice, have three children.

1971

Dr. James Barone, Apt. 201, 4101 Cornwallis Dr., Virginia Beach, Va., has been cruising the Mediterranean in the Navy. His ship participated in the evacuation of Americans from Lebanon. His wife has followed the ship from port to port, visiting among other places Naples, Palma and Barcelona. He will be in Norfolk through February.

Dr. Thomas A. Brasitus, 3403 Fountain Ct., Montgomery, Al., finished his Fellowship at Beth Israel Hospital in Boston and passed his subspecialty boards in gastroenterology in October, 1975. He is now Chief of Internal Medicine at Maxwell Regional F.B. Hospital. In July he will become Assistant Professor of Medicine at Columbia Presbyterian Hospital in New York.

Dr. Howard S. Robin, 6625 Lipmann St., San Diego, has been awarded a post-doctoral research Fellowship in the Scripps Clinic and Research Foundation's Department of Molecular Immunology. Dr. Robin is a certified clinical and anatomical pathologist.

Dr. Augustin J. Schwartz, III, 705 N. Olive Ave., West Palm Beach, Fl., has been appointed a Clinical Assistant Professor in the Department of Oncology at the University of Miami School of Medicine. He was also elected to the Board of Directors of the Palm Beach County Chapter of the American Cancer Society for 1976-77. He invites any of his classmates to visit when they are in the area.

1972

The first reunion! Our fifth is scheduled for Saturday June 11 at Jefferson Alumni Hall. Facilities will be shared with the class of 1967 that evening for cocktails, dinner and dancing announces Ned Russell, Chairman.

Dr. William D. Boswell, Jr., married Dr. Joan K. Feltman in August. Dr. Boswell is a supervisor of resident physicians at the Southern California Medical Center and a Clinical Instructor in Radiology at U.S.C.'s Medical School. The couple lives at 10290 Cheviot Dr., Cheviot Hills, Los Angeles.

Dr. Rodney D. Dorand has become Director of the Regional Neonatal Intensive Care Nursery in Montgomery, Alabama, effective July 1, 1976. The nursery opened on this date under his direction and supervision. It is a regional referral unit located at Baptist Medical Center in Montgomery, and he serves as the neonatologist to the entire south central portion of the state of Alabama.

After graduation from Jefferson in 1972, Dr. Dorand spent four years at the University of Louisville Children's Hospital in Louisville, Kentucky, where he completed his internship, residency and a two-year Fellowship in neonatology.

He is presently residing in Montgomery with his wife Linda, and their three children, Leigh, Meredith, and Kyle.

Dr. Martin J. Fliegelman, 2849 Briarcliff, Ann Arbor, Mi., is a senior medical resident at the University of Michigan, leaning toward a renal or pulmonary subspecialty.

Dr. Mark Josephs was married in October to Linda Jean Stoecker. Dr. Josephs is Director of Emergency Services at Merced, California, Community Medical Center.

1973

Dr. Michael H. Bryant, R.D. #3, Box 45, Danville, Pa., will take a year off and work in a clinic in Bora Bora.

Dr. Steven A. Burger, 1802 Windsor Dr., Framingham, Ma., completed his residency at Washington Hospital Center and is now a Fellow in gastroenterology in a combined Boston City Hospital and University Hospital program. He and his wife, Linda, have a son, David, born October, 1974 and a daughter, Lisa, born April, 1976.

Dr. John W. Cochran, 175 N. Grove, Oak Park, Il., writes that Arlene received her M.A. in learning disabilities last spring from the University of Illinois. Dr. Cochran is a recent Diplomate of the American Board of Internal Medicine and is a resident in adult neurology at Presbyterian-St. Luke's Medical Center, Chicago.


Dr. Thomas R. Layton, 2406 Beechwood Blvd., Pittsburgh, is a third year resident in general surgery at Mercy Hospital.

Dr. Joseph P. Mullen, III, Oak Hill Estates, Penn Valley, Pa., will begin a residency in urology at the University of Pennsylvania in July 1977.

Dr. Bruce E. Jarrell and Dr. Leslie S. Robinson, 1700 Winding Ridge Dr., Richmond, Va., announce the birth of their first child, Noble Evan, on October 1, 1976. Dr. Robinson, a Diplomate of the American Board of Internal Medicine, is engaged in the private practice of internal medicine.
Dr. Kevin T. Tracey, 263 Tanglewood Dr., Osterville, Ma., is practicing primary care and internal medicine in Centerville on Cape Cod.

1974

Dr. Joseph R. Berger, 3915 W St., N.W., Washington, D.C., is married to Sandra Gall Taff, a 1970 graduate of the University of Pennsylvania. He is completing his residency in internal medicine at Georgetown University Hospital and will be spending next year in Israel.

Dr. William J. Gibbons, Hampton Crossing Apts., Southampton, Pa., writes that he married Mary Smylie on October 9, 1976.

Dr. Victoria A. Gillis, 18223 Lahser Rd., Detroit, MI., will be Chief Resident in medicine at Henry Ford Hospital for 1977-78.

Dr. Larry R. Leichter, 200 Carman Ave., East Meadow, N.Y., will complete his internal medicine residency at Nassau County Medical Center and start a Fellowship in gastroenterology at the New Jersey College of Medicine in July. Dr. and Mrs. Leichter announce the birth of their daughter, Michelle Ilyse, on August 24, 1975.

Dr. John P. Lubicky, 5723 Westover Dr., Richmond, Va., married Vicki Lynn Kaufman in April, 1976. He is Assistant Resident, Division of Orthopaedic Surgery, Medical College of Virginia Hospitals.

Dr. William M. Schulman, 325 N. 15th St., Philadelphia, is a surgery resident at Hahnemann Hospital.

Dr. Edward J. Share, 2704 4th St., Santa Monica, Ca., will complete his residency in internal medicine at USC Medical Center in July 1977 and then begin a Fellowship at Boston University Medical Center.

Dr. L. Peter Soraru, IV, 1125 Rodman St., Philadelphia, will complete a family practice residency at Wilmington Medical Center in June.

Dr. Robert J. Wasnick, 101 W. 15th St., New York City, married Carla M. Madonia on September 18, 1976 in New York.

Dr. Steven Zamore was married to Peggy Ann Ravich. Dr. Zamore is a resident in ob/gyn at Yale/New Haven Hospital Medical Center.

1975

Dr. Jerry M. Belsh, 325 N. 15th St., Philadelphia, is in a neurology residency at Hahnemann.

Dr. Joseph B. Giletto, 2020 Locust St., Philadelphia is a surgical resident at Misericordia.

Dr. John E. Hocutt, Jr., 4005 Golfview Dr., Newark, De., received the Mead Johnson Award for 1976-77 for family practice residents.

Dr. Nathan A. Jacobson, 7830 Camino Road, Miami, writes that he is alive and well with his wife, Ricki, just celebrating their first anniversary. He is a medical resident at Jackson Memorial Hospital.

Dr. Thomas M. Malachesky, Geisinger Medical Center, Danville, Pa., is a pathology resident at the above center. He and his wife had a baby girl, Amanda, on December 20, 1975.

Dr. Richard P. Marcello, 21st & Hamilton Sts., Philadelphia, and his wife, Linda, are happy to announce the birth of their daughter, Megan Elisabeth. Dr. Marcello is in the first year of residency at Wills Eye Hospital.

Dr. F. Harland Miller, 670 Meadowbrook Dr., Huntingdon Valley, Pa., is working full time at Holy Redeemer Hospital as an emergency room physician.

Dr. Thomas M. Mizianty, P.O. Box 5090, Wilkes Barre, Pa., a family practice resident in Kingston, recently joined the Luzerne County Medical Society.

Dr. Stephen C. Mory, 765 Sylvester Way, Apt. B-3, McKeesport, Pa., writes that he and his wife, Lorraine, are expecting a baby in November.

Dr. Stanley Scott Paist, III, Highland Hospital, Rochester, N.Y., announced the birth of a daughter, Alice Rebecca, born February 3, 1976.


Dr. Robert T. Sataloff, 3040 Lorraine St., Ann Arbor, Mi., has completed a year of general surgery at the University of Michigan and has begun an ENT residency there. “Still singing but no conducting since leaving the TJu choir. Was married on October 17 to Dahlia Mishell, a third year medical student at the University of Michigan and a concert pianist.”

Dr. Vernon Van Bolden, Jr., has graduated from the U.S. Air Force School of Aerospace Medicine and has been assigned to Dover AFB in Delaware as a flight medical officer.

Dr. Roy T. Veve, 1111 Ariola Dr., Pensacola Beach, Fl., is an ob/gyn resident, enjoying the beautiful Florida sun.

Dr. Justin F. Weiss, 5763 Placita Bacanora, Skyline Bel Air, Tucson, Az., married Meg Ellen Shearn, a graduate of the Jefferson School of Cytotechnology on June 30, 1976.

1976

Dr. Richard Whittington, Hahnemann Medical College and Hospital, Philadelphia, married Jane L. Coleman in August.

Faculty

Dr. E. Frederick Wheelock, Professor of Microbiology, has been elected a Term Trustee at Drexel University.

The Election Ford Won

As far as the Jefferson medical student body is concerned, Gerald Ford should be President, not Jimmy Carter. So, at any rate, the results of an American Medical Student Association (AMSA) questionnaire on Campaign '76 would suggest. Out of 205 responses, Ford topped Carter 95 to 69 despite a greater number of registered Democrats reporting. It is perhaps no coincidence that most students identified Mr. Carter with national health insurance and Mr. Ford only with catastrophic coverage.

Students judged physicians the most able to solve the problems of the medical profession and the government least able. Only one-third of the students, however, felt qualified to discuss NH with their peers, and the poll split evenly on the issue with 55 “undecided.” Not surprisingly, survey respondents in the main rejected government control and interference in their various manifestations, but accepted federal subsidy of medical schools in theory and in fact.

And if we can correlate response with interest, the poll certainly indicates that politics is not a burning concern at Jefferson. Those 205 respondents came from a possible number of 896 medical students, all of whom received the questionnaires in their student mailboxes.
Charles Butcher, 1909
Died August 29, 1976. Dr. Butcher had a family practice in Heislerville, New Jersey and was physician to Leesburg State Prison for 55 years. He is survived by a daughter.

William H. Annesley, 1911
Died December 6, 1976 at the age of 88. Dr. Annesley was a general practitioner in Philadelphia until 1942 when he began a practice in ophthalmology. He was Chief of that specialty at Northeastern Hospital and an Associate at Lackenkau Hospital. Dr. Annesley is survived by a son, Dr. William '48 and a daughter.

George A. Brown, 1914
Died November 30, 1976 at the age of 85. A physician in Water Valley, Mississippi, Dr. Brown helped establish the Water Valley Hospital and was Chief of Staff from its inception in 1919 until it was closed in 1961. He served as Chief of Staff of its replacement hospital, Yalobusha General. He had been an Associate in Clinical Surgery at the University of Mississippi, was District Surgeon of the Illinois Central Railroad, a Fellow of the American College of Surgeons and a member of many professional societies. He received a tribute dinner from his community in 1958. He is survived by his wife, Dorothy, a son, and three daughters.

Joseph F. Comerford, 1917
Died September 11, 1976. He was a regional medical officer for the Veterans Administration and Hospital in Wilkes-Barre, Pennsylvania and was a staff physician at Farview State Hospital, a post from which he retired two years ago. Dr. Comerford was President of the Lackawanna County Medical Society for several terms. He was affiliated with several Scranton area hospitals. Dr. Comerford is survived by a daughter and three sons.

John F. Owen, 1920
Died March 11, 1976. He was certified by the American Board of Psychiatry and Neurology. Dr. Owen lived in Raleigh, North Carolina.

William A. Wallace, 1920
Died December 9, 1976 at the age of 82. Dr. Wallace served as Head of the Department of Radiology at the King's Daughter Hospital in Martinsburg, West Virginia, where he had played an active role in its construction. He was a former President of the Eastern Panhandle Medical Society, the Kiwanis Club and the Berkeley County Chapter of the Izaak Walton League. He also served the latter as Vice-President on the National Board and was known as an early conservationist and environmentalist. Dr. Wallace was a Diplomate of the American Board of Examiners of Radiology. He had served on the Boards of the Potomac Light and Power Company and the Citizens National Bank. Surviving are his wife, Elizabeth May, three daughters, one of whom is Mrs. John H. Hodges, wife of the Ludwig A. Kind Professor of Medicine at Jefferson, and five grandchildren.

Jacob K. Berman, 1921
Died November 17, 1976 at the age of 80. He had been a Professor of Surgery at the Indiana University Schools of Medicine and was named Emeritus Professor in 1968. Since 1971 he served as a Visiting Professor of Surgery at Jefferson. A former President of the Staff at St. Vincent and Wishard Hospitals, he had also been President, Chairman and Executive Committee member of the Western Surgical Association. He was a founding member of the American Board of Surgery, a founding member of the Central Surgical Association and a member of the Société Internationale de Chirurgie and many others.

He invented the Berman tube for chest surgery, the Berman clamp for vascular surgery and the Berman balanced procedure for correction of hiatal hernia complex. He was also founder and former editor of the Indiana University Medical Center Quarterly Bulletin. He is survived by his wife, Henrietta, two daughters and a son.

Francis I. Haggerty, 1923
Died July 31, 1976. Dr. Haggerty was a family practitioner in Springfield, Massachusetts. He is survived by his wife, Mary.
Just one year ago, JAB reported to you that ground breaking ceremonies had been held on November 21, 1975, for the new Thomas Jefferson University Hospital. On October 28, 1976 there was a topping off ceremony. The nine floor facility which will provide both the total range of patient care and the educational experience, covers the Chestnut, Sansom, Tenth and Eleventh Streets block. This photo looks east with the Thompson Annex and Foerderer Pavilion on the right.
ALUMNI CALENDAR

February 23-25
Modern Therapeutics, Jefferson Medical College

February 24
The Annual Dinner and Business Meeting of the Alumni Association, Pennsylvania Historical Society, Philadelphia

March 16-18
Ambulatory Care in Obstetrics and Gynecology, Jefferson Medical College

March 18
Parents' Day for Sophomore Students, Jefferson Alumni Hall, sponsored by the Alumni Association

March 31-April 1
Advanced Electronystagmography Course, Jefferson Medical College

March 31-May 5
(Thursday afternoons) Otolaryngology for the Primary Physician, Jefferson Medical College

April 15-May 1
15th Postgraduate Medical Seminar, Italy/Cote d'Azur

April 19
Reception and Dinner, The Fairmont Hotel, Dallas, in conjunction with the meetings of the American College of Physicians. Special Guest: Frank D. Gray, Jr., M.D., Magee Professor of Medicine

April 26
Reception, The Palmer House, Chicago, in conjunction with the meetings of the American Urological Association

May 4
Reception, Toronto, in conjunction with the meetings of the American Psychiatric Association

May 9
Reception, Chicago, in conjunction with the meetings of the American College of Obstetricians and Gynecologists

May 14
Reception to honor John S. Madara, M.D., '45, President of the Medical Society of New Jersey, Haddon Hall

June 8
Clinic Program, Dean's Luncheon, Class Parties (see class note section)

June 9
Alumni Banquet, the Hyatt House, Cherry Hill