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Boston University

P R O G R E S S

OCTOBER 1989



The
University
Hospital
Magazine

TRAUMA

CARE:

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COUNTS**





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On the cover: The Boston Medflight helicopter over the University Hospital's Atrium Pavilion. Photograph by Lou Jones (copyright ©1989). Special thanks to Boston MedFlight.

PROGRESS

C O N T E N T S

**Trauma Care:
When Every Second Counts**

Trauma is the leading cause of death among people under age 44. Skill, timing and teamwork are key ingredients in the care delivered to the estimated 1,200 trauma patients who are brought to Boston Emergency Medical Center each year.

PAGE **2****'High Quality, Zero Defects'**

In a candid interview, UH President J. Scott Abercrombie Jr., M.D., shares his views on such questions as: Is quality of care being compromised by the health-cost crunch? Is Boston really a medical mecca? Are hospitals becoming too "bottom-line" oriented? Can universal health care work?

PAGE **6****Keeping America Healthy At Work**

Occupational medicine is playing a major role in the health of the American worker. By working with business and industry, the UH Occupational Health Program has helped many employers realize that the cost of keeping their employees healthy at work is the most sound investment they can make.

PAGE **8****A Classical Approach
To Fighting Cancer**

A new "designer" drug, created through genetic engineering, attacks and kills leukemia and lymphoma cells. The drug, now in clinical trials, may be useful in fighting other autoimmune diseases and could serve as a model for future drug research.

PAGE **11****Facing The Facts**

Even with a greater awareness, 400,000 Americans will be diagnosed with some form of skin cancer this year. The UH Skin Oncology Program offers a full range of specialists to deal with complex skin tumors and cancers.

PAGE **14****News & Names**

In memory of Joseph Stokes III, M.D....New appointments at the Hospital...UH people honored for achievements...A Gala Event...Staff members in the news.

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About the University Hospital

The University Hospital, founded in 1855, is a teaching hospital of Boston University School of Medicine. The Hospital provides a full spectrum of medical services. Its 379 beds include many special-care units, including psychiatry, coronary care, metabolic, medical intensive care, surgical intensive care, the Northeast Regional Center for Brain Injury, the New England Regional Spinal Cord Injury Center, the Wald Neurological Unit, the Respiratory Care Center, the New England Male Reproductive Center and the University Continence Center. The University Hospital, Boston University School of Medicine and the University's Goldman School of Graduate Dentistry constitute Boston University Medical Center.



MR MASSACHUSETTS

When 27-year-old John McClay, a 5-foot 11-inch, 230-pound body-building champion, left the LA Fitness Center in Rockland, Mass., to jog with a companion one warm February evening in 1985, little did he realize that the events to occur that night would change the course of his life.

Fifty yards down the road, McClay was hit from behind by an automobile being driven at 50 mph by a drunk driver, and he was thrown 40 feet over the guardrail.

When paramedics arrived on the scene, McClay was lying unconscious on the ground; his blood pressure was alarmingly low. A victim of multiple trauma, McClay suffered injuries ranging from a closed head injury, broken back and a fractured pelvis, to a shattered hip and knee, and a stomach and part of a leg buttock that were ripped open. Within minutes, a priest arrived on the scene to deliver last rites.

McClay was rushed to South Shore Hospital in South Weymouth, where he was stabilized, evaluated and then transported to the Boston Emergency Medical Center (BEMC), the joint trauma center of the University Hospital and Boston City Hospital, in the South End.

When he arrived at BEMC, a highly skilled team of surgeons—consisting of a neurosurgeon, a trauma surgeon and an orthopedic surgeon—worked simultaneously and in unison for almost six hours to repair trauma to McClay's brain, abdomen, and a host of fractures. He required 19 units of blood to compensate for the five to six liters he had lost since his accident. Following surgery, he was brought to the Surgical Intensive Care Unit at UH, only to return to the operating room several times for reconstructive surgery.

Few people believed John McClay would recover from his tragic accident to lead a vibrant life.

That was four years ago. Today, McClay has seemingly beaten all odds. He is an A student at the Suffolk University Graduate School of Business, where he will obtain his master's degree in business administration (MBA) next spring; he is looking for a management position with a large firm. He also continues to work out four times a week at the gym, and he even serves as a judge for state amateur bodybuilding contests.

BOSTON EMERGENCY MEDICAL CENTER

Where UH and BCH trauma experts combine skill, timing and teamwork to save lives

BY CYNTHIA L. PARADIS

John McClay had been in a coma for three months when he awoke in a University Hospital bed in May of 1985. He still doesn't remember being hit from behind on Feb. 22, 1985, nor does he remember the lifesaving efforts that allowed him to wake up again.

"I'm lucky to be alive," McClay acknowledges, "And I feel the reason I am alive is because of the quick care I received the night of my accident. But if I wasn't such a fighter, I wouldn't have made it this far. Some days I wished I were dead, but then I tell myself to 'hang in there and be tough.'"

His wife, Donna, whom he had married several months before the accident, is his best friend and biggest supporter. After spending 2 1/2 years in four different hospitals following his accident, he returned to their home in Weymouth, where he now moves about freely using a walker.

McClay has become actively involved in his rehabilitation since his accident, which has left him permanently disabled from the waist down. He has returned to the LA Fitness Center, where he used to train six days a week, two hours a day, for state and na-

tional body-building competitions. [In 1981, McClay earned the title "Mr. New England" and he placed fourth in the "Mr. America" contest a year later.]

Today, while his workouts are not nearly as intense and regimented, they are an integral part of his rehabilitation, consisting of light-weight, upper-body repetitive exercises. "If I quit, I may as well be dead," he says.

Erwin F. Hirsch, M.D., chief of the UH Trauma Section and the attending surgeon who supervised McClay's care that evening four years ago, recalls the extent and complexity of his injuries. "Basically, three operations were being

■ FOR YOUR INFORMATION

Dr. Hirsch is director of Boston Emergency Medical Center (BEMC), chief of the UH



Trauma Section, director of General Surgery at Boston City Hospital, and is an associate professor of surgery at Boston University School of Medicine.

If you would like more information about BEMC, please call 1-800-842-3648.

conducted simultaneously, since his injuries were all life-threatening," he says. "Mr. McClay's situation required major-league involvement of a variety of surgical specialists. We did what we could in a timely, expert fashion, but luck also was on his side." UH neurosurgeon Joe Ordia, M.D., and orthopedic surgeon Isadore G. Yablon, M.D., worked with Hirsch that evening.

A deadly epidemic

Trauma is an epidemic; in fact, it is the leading cause of death among people under age 44. An estimated 140,000 Americans die each year from trauma and more than 300,000 others are permanently disabled as the result of traumatic injury.

Recognizing that prompt and skilled care can mean the difference between life and death, or between a full recovery or permanent disability, UH and Boston City Hospital have joined forces to provide high quality, innovative trauma care. Together, UH and BCH form a trauma center known as Boston Emergency Medical Center (BEMC), one of three designated Level I trauma centers in Metropolitan Boston.

Most often, trauma patients are stabilized in the BCH emergency room—one of the highest volume ERs in the country—and then receive their specialized care at UH. With such strengths as Med Flight, a medical emergency helicopter, and helipad facilities for quick access, the trauma center can treat patients with life-threatening injuries at a moment's notice.

More than 1,200 trauma patients are brought annually to BEMC, where appropriate staffing, expertise, service and technology are available 24 hours a day. Patients whose conditions are too severe or complex for emergency rooms in other Massachusetts hospitals or hospitals

Mary Howard Scott: Airlifted to safety



Mary Howard Scott, 41, of Kennett Square, Pa., was vacationing on Nantucket this past summer when she suffered severe head trauma after falling from her bicycle. Within four hours of her accident, Scott was undergoing emergency surgery at the University Hospital in Boston for a skull fracture and a subsequent blood clot on the surface of her brain, which would have killed her had she not been given prompt care.

Scott was initially rushed in a

coma to Nantucket's Cottage Hospital, where it was determined that she needed the facilities that only a trauma center could provide. Shortly thereafter, she was airlifted to BEMC via Boston MedFlight, an emergency medical helicopter that has proven over the past several years to be a key to immediate and efficient care for many trauma patients.

"Mrs. Scott's injuries were life-threatening and could have caused either a stroke or death had she not received prompt attention," says Scott's attending physician at UH, Edward Fischer, M.D., a neurologic critical care

specialist.

The care that Scott was given allowed her to leave the University Hospital one week after her accident—an incredibly short hospitalization for a trauma patient, Fischer says. A full recovery is expected.

"Without the helicopter, it would have taken closer to 10 hours to get care to Mrs. Scott," says Terence G. Dougherty, administrative director of Boston MedFlight. "The only other alternative would have been a ferry and

in nearby states are brought to the center, either directly or after being given initial care elsewhere.

The two T's: trauma, teamwork

The Boston Emergency Medical Center is an integrated system. "Trauma care requires a team of professionals who understand all aspects of quick, responsive medicine," says Hirsch, the director of BEMC and the director of General Surgery at Boston City

Hospital. "A surgeon alone, in any type of trauma case, will never be the sole determinant of success or failure. There must be the presence of other staff—countless others—to care for a patient effectively."

The best outcomes for trauma victims rests on several key factors, Hirsch says:

- The promptness with which the care is administered,
- the capabilities, qualifications

that, alone, would have taken 3 1/2 hours, if it were in port."

Airlifting patients to safety

The University Hospital, which played the leading role in developing MedFlight, is part of a consortium of Boston's academic medical centers operating the 24-hour-a-day, seven-day-a-week service. Since airlifting its first patient on June 25, 1985, Boston MedFlight has transported more than 2,000 critically injured and critically ill patients to Boston medical centers. Last year, Boston MedFlight airlifted nearly 700 patients, 115 of whom were brought to BEMC. Most MedFlight missions are to transfer acutely ill patients from a suburban hospital to one of the Boston trauma centers.

Boston MedFlight is staffed by a critical care nurse trained in emergency medicine, a paramedic and a pilot. The nurse and paramedic work hand-in-glove until a patient is safely on the ground and hospital trauma personnel can take over the patient's care.

A virtual "ambulance in the



air," Boston MedFlight must meet all the requirements of an advanced life-support ground ambulance with regards to staff and equipment. Suzanne K. Wedel, M.D., a surgical critical care specialist in the intensive care units at both UH and BCH, says there are two advantages to using a helicopter in the care of trauma patients. "One is obviously speed; we can especially appreciate that, being in Boston with all its traffic congestion. The other advantage," she says, "is the impact of the helicopter medical team in beginning early resuscitation or stabilization. [The team] acts as an extension of the tertiary center emergency room or intensive care unit. It can bring tertiary care to patients quicker."

that direction together."

Even when all of these requirements are present, however, trauma care includes a bit of luck. No matter how prompt and skilled the care delivered to a patient may be, Hirsch says, "Sometimes, given the best efforts, things don't go well. Trauma has many different ways of presenting itself; this is not a predictable world." For example, a 58-year-old male, the victim of a train accident, was airlifted 2

1/2 hours to Boston City Hospital from a Maine town on the Canada/U.S. border and underwent eight hours of surgery, only to die the following night of a heart attack.

The dynamics of trauma

Hirsch is one of six academic trauma surgeons responsible for the admission and overall coordination of care for a trauma patient. The others are Desmond H. Birkett, M.D., Garry F. Fitzpatrick, M.D., Jonathan Woodson, M.D., Gene A. Grindlinger, M.D. and Riad Cachicho, M.D. "Each is totally qualified to manage, coordinate and administer the care of trauma patients," Hirsch says.

Hirsch explains that trauma is divided into two categories—blunt or penetrating. Approximately 45 percent of BEMC's trauma patients are victims of "blunt" trauma; that is, trauma that is caused by virtually any type of accident, such as an automobile or motorcycle accident. The remaining 55 percent of the Center's trauma patients are victims of "penetrating" trauma, or trauma from a gunshot or stab wound.

From the time a trauma patient is brought to the doorstep of BEMC to the time he or she is rehabilitated, the patient is given the tools needed to return to society.

"The end product of trauma care, if the outcome is good, is a totally rehabilitated, normal functioning person and that's part of the philosophy of trauma care," Hirsch says.

About some of his former patients, he notes, "They are really super people. It's unbelievable what a well-motivated, successfully rehabilitated patient can do."

and expertise of the trauma team,

- and the magnitude of the injury.

"The [people involved] in a patient's care should be so familiar with what has happened to the person that he or she can program a recovery phase, look for potential complications and deal with them before they become an issue," Hirsch continues. "That's part of the team effort—that everyone thinks in

'High Quality, Zero Defects'

A conversation with J. Scott Abercrombie Jr., M.D.



J. Scott Abercrombie Jr., M.D., has been the President of the University Hospital since 1980. During his tenure, Abercrombie has guided UH through years of prosperity and physical change, and is now steering the Hospital through a period of unprecedented challenges facing all hospitals, and teaching hospitals in particular. In an interview with **Progress** editor Mike Paskavitz, Abercrombie shares his views on health care at UH, in Massachusetts and throughout the country.



Progress: It has become clear that hospitals in Massachusetts have reached the crisis stage in their financial health. Why has this happened so quickly?

Abercrombie: The biggest single reason that hospitals are suddenly faced with financial difficulty is that the federal government has severely restricted Medicare payments. Hospitals in Massachusetts are now 100 percent under the national Medicare prospective payment system, which pays the same for a procedure in a Hawaii hospital as it does in a Mas-

sachusetts hospital, despite special circumstances or complications, or the relative costs of caring for the patient. Health care in this state has been more expensive than in most states, and we are now at the point where each Medicare patient costs us more than we are paid, whereas somewhere else in the country where the cost of caring for a patient is under the average Medicare payment, those hospitals are doing all right.

In other states where health care is as expensive as it is in Massachusetts, they can shift their costs to other payers in order to not absorb a loss from caring for a Medicare patient. However, hospitals in this state are prohibited by law from shifting costs. The Massachusetts Rate Setting Commission sets revenue limits for us, so if we in Massachusetts lose money on Medicare, we cannot make it up through private payers.

Now, if you have all of this, plus a governor and state legislature who don't pay their bills (in particular, Medicaid, which represents 11 percent of UH's budget), then that just adds to the problem.

Progress: Wouldn't hospitals in Massachusetts, which is considered a medical mecca, receive some sort of special consideration?

Abercrombie: I do not believe that Boston is quite the medical mecca it thinks it is. I think that the "mecca" changed after World War II, when the government began to distribute money differently. There is no longer a stronghold in medicine among the East Coast cities; there is more parity around the country. Stanford, for example, is the leading institution for heart transplants in the world; it's not in Boston. So a mecca is where the doctors and resources are. If Dr. [Norman] Shumway (a pioneer in heart transplantation at Stanford) were in Little Rock, Arkansas, that's

where the mecca for heart transplants would be. I do think that Boston still has the highest concentration of medical talent, because it's so small. And that isn't likely to change.

Progress: Are hospitals being forced to run more like traditional businesses, and is there a danger that quality of care might be compromised?

Abercrombie: I don't think that worrying about the bottom line necessarily implies a threat to quality of care. No matter how you look at it, hospitals have to aim at breaking even. It's a whole lot easier to provide quality when you're breaking even than when you're struggling to survive.

But I do think hospitals could be squeezed enough so that it could challenge the quality of care. To look at it from another perspective, the people who get no care in this country have poor health, so that too is considered poor quality.

In my view, the challenge in thinking about quality of care is to break away from thinking that there's only one way to provide quality. One should never believe that there is only one way for things to be done. I believe that we might be able to do things in a different way and deliver the same high quality care for less cost. We are now exploring what some of the alternatives are.

Progress: You've used the theme "High Quality, Zero Defects" to describe the University Hospital's approach to change. What does that mean?

Abercrombie: Let me premise this by saying that our approach is driven by what we call our Change Project. In my view, there are no gimmicks to this dilemma. It costs us more to care for patients than what we are paid for. Even if we increase our volume, we must reduce our costs.

The theme, "High Quality, Zero Defects," is not a perfect one, but it is appropriate. It relates to the principles of cost and quality. I think one should ask oneself why Honda owners have a 98 percent satisfaction rate, meaning that they would buy a Honda again. Why is that? That number is higher than for Mercedes Benz or Rolls Royce. On the other hand, why are the retention numbers for American car buyers, even the Lincoln, not nearly as high? I'm not exactly sure why, but I personally believe that it's because people will respect, and will even pay a premium for, quality. For what you pay for a Honda, you can get an American car that is one and a half times larger. Yet people choose to pay the premium for quality.

Even if we are the best, we can be better. The Trump Shuttle says it leaves the gate at 7:00, not 7:01. Obviously hospitals have many more variables in delivering quality patient care, but we do have to find ways of ensuring efficiency.

Progress: Does the University Hospital's respect for business principles extend to restructuring its services along "product lines," like so many hospitals have?

Abercrombie: Ours is certainly not what I think classic product-line management is, but we are moving in a direction where part of our structure is set up in a similar way to product-line management. The trend is to have managers responsible for certain groupings of related services.

A very good recent article by Jeff Goldsmith [*Harvard Business Review*, May/June 1989] talked about such issues. I was particularly in agreement with what was said about hospitals who have relied on retail strategies, such as merchandising, brand names and media campaigns, being casualties of this decade. Many hospitals tried to fill beds through marketing, while not concerning themselves with operating efficiency.

Also, what some strategies did was create systems that alienated the doctor from the patient. There is a sacredness to the doctor-patient relationship that should not be undermined by systems. Here at UH, as best we can, we are intending to wed the operations-driven management

style with the marketing-driven style. I really think you have to do it that way. Quality of service is far more critical than organizational design, and that's the way we're approaching our Change Project.

Progress: The Massachusetts Universal Health Law (Chapter 23), which calls for increased government involvement in assuring access to health services, is said to be highly flawed, so is the prospect of universal health insurance unrealistic?

'There are so many people living in the streets of this country, yet we demand the very best medical care'

Abercrombie: First of all, how do we know whether Chapter 23 is disastrous, since it has hardly been put into place. It may, indeed, prove to be disastrous because it hasn't been funded properly, and it puts a great burden on small businesses.

The problem with universal health schemes—whether local, state or national—is funding. Who will pay for it? I would grant that those who conceive these plans are interested in access to care, but they haven't figured out a way to pay for it. And if they believe that health care can be delivered more cheaply on a state or national scale, they're mistaken.

Right now, no one is paying for the health care of 39 million Americans. Isn't it awful that so many Americans can't receive care? But another question is: what will happen if you add to an already flawed system another

39 million people who aren't even paying right now? The cost of providing just basic health care would be staggering. The funding issue is usually the last thing to be dealt with by those who propose such plans.

Some would argue that we in this country already pay enough for health care, but that it's not distributed properly. If that's so, then why not deal with that first, rather than figuring out a way to bring everybody into a flawed system?

I also don't like anything that considers health care in Alaska to be the same as it is in Arkansas; it is bound to be wrong. That's part of the trouble with Medicare: it considers the health care needs of the Eskimos in Alaska the same as the needs of farmers in Arkansas. What is not understood is that Tip O'Neil's (former Speaker of the U.S. House of Representatives) statement about politics ('all politics is local') applies to health care as well—it is very local. Health care is not the same in Chelsea as it is in Milton.

Here's a radical thought for a hospital CEO: medical care may be viewed as more important than it should be. Food and housing are certainly more important. Running water is more important. In some cases, garbage collection may be more important. While we see a great number of people living in the streets of this country, we all demand the best medical care. I'm not saying I'm opposed to an all-encompassing system, but there would be a lot to talk about and there may be more important problems to address first.

Progress: What is your outlook for UH as we enter the next decade?

Abercrombie: It would be my objective to have UH emerge stronger, relative to other hospitals. It may be that all hospitals will be in poorer shape in five years than they are now. But I expect us to persevere. We have a strong medical school whose stature is becoming more clearly acknowledged in the Commonwealth. We have a bright and committed medical staff. I also think we have many fine young, dedicated managers with ideas. That gives me a strong sense of optimism. But it all comes back to quality; we have to be both efficient and good.

KEEPING AMERICA

An employee at a major metropolitan newspaper, who uses chemical solvents in his hands-on pressroom work, is afflicted with numbness and tingling in his fingers and hands.

Several workers at a styrofoam plant experience symptoms of impotence and urinary problems that are traced to a chemical used in the manufacturing process.

These cases typify the work-related problems seen by the University Hospital's Occupational Health Program (OHP), the only such full-time, full-service program in Boston, and one of

only 25 in the country with a residency training program. The OHP's involvement in workplace illnesses has grown dramatically in recent years, reflecting what appears to be a major recognition of occupational health by industry and business.

As recently as 15 years ago, the relationship between medicine and industry was less than harmonious. Today, however, it is becoming apparent that keeping employees healthy, fit and productive is the most sound investment a business can make. Employers now find it practical to hire physicians to evaluate their work sites and their employees for health risks.

Robert J. McCunney, M.D., clinical director of the OHP, says, "We believe that people should not compromise their health because of work, and that point of view is now being embraced by workers, employers, unions and legislators."

Occupational medicine dates back to the 17th century, when Italian physician Bernardino Ramazzini, the "Father of Occupational Medicine," studied the health problems of laborers.

Perhaps the most well-known occupational health problem was the rampant sickness among workers in the Chicago meat-packing industry around the turn of the 19th century (chronicled in Upton Sinclair's landmark novel, "The Jungle").

Such working conditions do not exist today, in an era of rigid state and federal occupational health and safety laws and space-age technology, but people still get sick or hurt at work. Despite all the laws and safety advancements, some 100,000 Americans die each year from occupation-related illnesses, twice the number that die annually in auto accidents. Most experts feel that this number is grossly underestimated, since many deaths are not traced back to possible contributory factors.

The University Hospital's involvement in occupational medicine began in the 1950s, when pulmonary specialist Edward Gaensler, M.D., helped to pioneer research in asbestos-re-



HEALTHY AT WORK

lated lung disease. This leadership, and the expertise in occupational neurology of current OHP medical director and UH chief of neurology, Dr. Robert G. Feldman, formed a firm foundation for today's program.

According to Feldman, the UH program serves three primary purposes: to provide clinical services to diagnose and treat work-related illness or injury; to educate physicians, workers and employers about occupational risk factors

and preventive measures; and to perform research into the causes and effects of occupational illness and injury. This triple mission is the heart and soul of American teaching hospitals, where major resources can be brought to bear on a pervasive health problem.

"The [OHP] is a conduit for a medical center, a point of entry into the health care system," says Feldman. A multidisciplinary medical center is an ideal setting for such a program, since many clinical services, such as in-

ternal medicine, radiology, dermatology, orthopedic surgery, physical therapy, cardiac rehabilitation, pulmonary medicine, and neurology, are often required.

The formation of the Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) have "advanced the field and earned greater respect from the medical community, the legislature and business leaders," says Feldman.

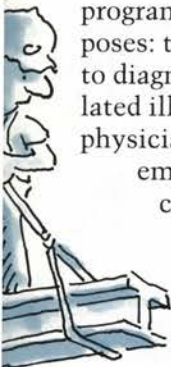
Ninety percent of American companies have fewer than 100 employees and few have in-house occupational health programs. But it is the major corporations who have realized the long-term benefits of having healthy employees. The OHP has a client list that includes the Boston Police and Fire Departments,

Northwest Airlines, the Digital and Teradyne corporations, and other business leaders.

Prevention through research

Occupational health has an epidemiological focus: For many patients, treatment is available for a work-related injury or illness, but as Feldman points out, "Most times, the damage has already been done. We are as concerned about the research value of individual cases as we are about treating each case, because we can learn something from the individual case that can lead to preventive measures," he says.

For example, several top workers at the Sprague Electric Company in Sanford, Maine, suffered from carpal tunnel syndrome—a condition where constant wrist movement causes nerve damage to the hand and arm. By working with the OHP, the company discovered that the conditions were caused by the design of their machinery. A resulting design protected workers from further injury and saved the company considerable



SOME HAZARDS IN THE WORKPLACE

In 1983, NIOSH published its list of the ten leading work-related diseases and injuries (the accompanying conditions and examples are merely selected samples; they are not comprehensive, categorical definitions):

1. Occupational lung disease—such conditions as asbestosis, silicosis, coal workers' pneumoconiosis, lung cancer and occupational asthma. *EXAMPLE:* Each year, an estimated 65,000 Americans develop a work-related respiratory disease, and about 25,000 deaths are attributed to occupational lung disease annually. Although typically associated with miners, laborers and chemical workers, this affliction has also been found in certain office workers. Most indoor illnesses are associated with chemically contaminated air ventilation systems.

2. Musculoskeletal injuries—including disorders of the back, trunk, upper extremity, neck, lower extremity; traumatically induced Raynaud's disease. *EXAMPLE:* Those who work at video display terminals (VDTs) are considered at risk for visual problems brought on by eye strain and for "ergonomic" injury—back, shoulder or neck injuries from sitting in a poorly designed chair.

3. Occupational cancers (non-pulmonary)—such diseases as leukemia; mesothelioma; cancers of the bladder, nose and liver. *EXAMPLE:* Many chemical agents and pollutants carry a long-term risk for cancer. Bladder cancer has been found in industrial laborers who work regularly with 4-aminobiphenyl, Auramine, Ben-zidine and 2-naphthylamine.

4. Severe occupational traumatic injuries—such as amputations, fractures, eye loss, lacerations and traumatic deaths. *EXAMPLE:* Many laborers and workers, such as those who work with heavy equipment, are at risk for traumatic injury.

5. Occupational cardiovascular diseases—such conditions as hypertension, coronary artery disease and acute myocardial infarction. *EXAMPLE:* Carbon monoxide, the chemical emissions from automobile engines, causes drowsiness and headaches, but studies in Los Angeles also linked carbon monoxide to an increase in emergency room cases of anginal chest pain.

6. Reproductive disorders—such conditions as impotence, infertility, spontaneous abortion and developmental abnormalities in fetuses. *EXAMPLE:* The agent dibromo-3-chloropropane, used by pesticide production workers, has been linked to sterility and impotence; and lead is considered a risk factor for miscarriage, birth defects and male infertility.

7. Neurotoxic disorders—such conditions as peripheral neuropathy, toxic encephalitis, psychoses, extreme personality changes (exposure-related). *EXAMPLE:* Nearly 200 of the more than 60,000 chemicals manufactured or used in the U.S. could be listed as carcinogens; another 2,000 are potential carcinogens. Long-term contact with harmful solvents and chemicals could cause neurologic damage, lung disease, cancer, diseases of the vital organs, birth defects and genetic changes.

8. Noise-induced hearing loss—Of the 105 million workers in the U.S., OSHA estimates that almost 14.5 million workers are exposed to noise levels loud enough to lead to short- and long-term hearing loss. Damage from noise exposure begins at 75 decibels, about the noise level of traffic at a major intersection. The standard for a work environment is 90 decibels.

9. Dermatologic conditions—such conditions as dermatoses, scalding burns, chemical burns and contusions and abrasions. *EXAMPLE:* Contact dermatitis, an inflammation of the skin, is caused by nickel and rubber compounds; and those who work in cold temperatures are also vulnerable to skin conditions, such as Raynaud's disease.

10. Psychologic disorders—such conditions as neuroses, personality disorders, and substance abuse. *EXAMPLE:* Stress is a common byproduct of many jobs; a bored assembly line worker may suffer stress levels equal to that of a stockbroker. Stress has been associated with substance abuse, and also has been shown to contribute to hypertension, a major risk factor for coronary heart disease.

health, disability and workers' compensation costs.

Many corporations are expanding their occupational health programs to include "wellness" programs, which can involve nutrition counseling, weight control, smoking cessation, blood pressure and cholesterol screenings, and stress management.

With the recent passing of the federal Drug Free Workplace Act, the OHP has begun to provide assistance to companies in developing drug policies, performing testing and evaluating specimens.

Another key element is evaluation. Feldman and McCunney spend a great deal of time investigating whether a disease is work-related and whether a job task is responsible. For instance, if a worker has a pulmonary disorder, is it due to exposure to chemical toxins at work or the result of a chronic smoking habit? The conclusions have major ramifications.

Michael R. Paskavitz

■ FOR YOUR INFORMATION

Dr. Feldman is medical director of the OHP, chief of neurology at UH, chairman of the Department of Neurology and professor of neurology and pharmacology at Boston University School of Medicine, as well as a professor of environmental health at the School of Public Health.



Dr. McCunney is clinical director of the OHP and Employee Health at UH, and is an assistant professor of public health at Boston University School of Public Health.



If you would like more information on the OHP, please call 1-800-842-3648.



A Classical Strategy To Defeat Cancer

An innovative 'designer' drug that kills leukemia cells may have other exciting possibilities

The struggle against cancer has traditionally been likened to a war. The classic tale of the Trojan Horse—which, pulled inside the city walls of ancient Troy, was found to be filled with conquering Greek soldiers—has a modern-day counterpart. A new drug under study at the University Hospital has been described as a

Trojan-Horse approach to cancer treatment because it appears as a "friendly" protein to certain cancer cells, yet it carries within its structure a deadly toxin.

After several years of intensive research at UH, this unique drug, known as IL-2 toxin, is now being used in patient trials at UH and the M.D. Anderson Cancer Center in Houston, Texas. These clinical trials will test the new genetically designed drug, which attacks and kills malignant cancer cells in patients afflicted with certain leukemias or lymphomas. The drug is the result of the genetic fusion of two separate natural proteins—interleukin-2 and diphtheria toxin—to create a hybrid protein.

"IL-2 toxin is the first 'designer' biological drug," says John R. Murphy, Ph.D., chief of Biomolecular Medicine at UH and creator of the drug. "It is an absolutely novel approach that combined two separate natural proteins to create a third protein."

The drug, which is produced by the biotechnology firm Seragen, Inc., is absorbed by lymphoma or leukemia cells that have receptors for the interleukin-2 portion of the molecule; interleukin-2 is a growth factor or "nutrient" for certain cancer cells. Because the cancer cell recognizes interleukin-2 as "food," it allows the IL-2 toxin to enter the

cell. Once inside the cell, the diphtheria toxin portion of the protein separates itself from the IL-2, and attacks and kills the cancer cells.

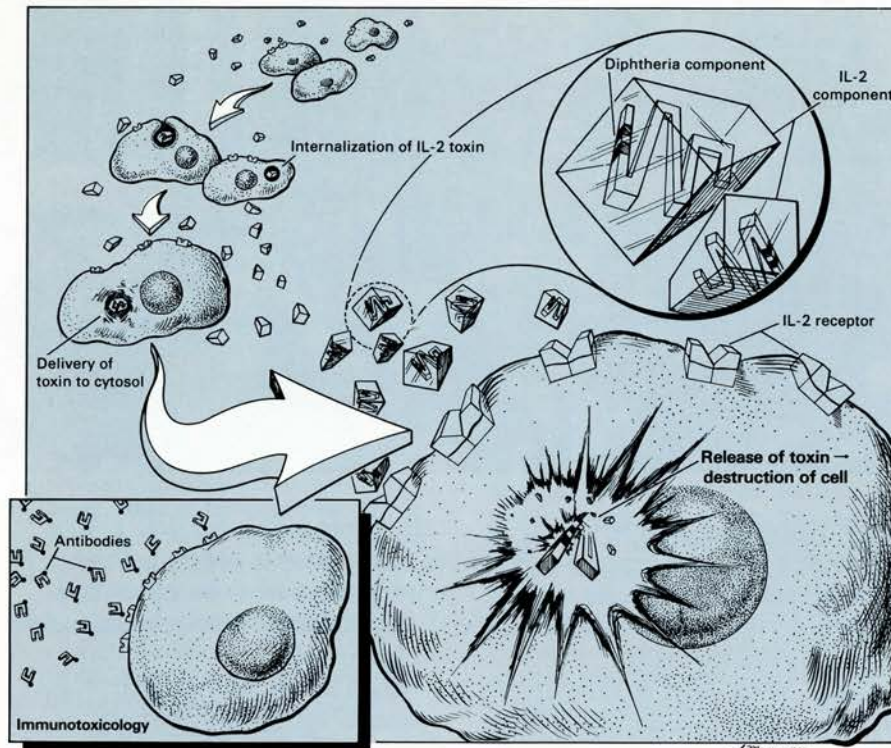
This innovative research rivals a parallel approach to cancer therapy which employs drugs known as immunotoxins. These drugs, which are formed by attaching a toxin to an antibody, bind themselves to cancer cells but often are unable to actually get inside the cell the way IL-2 does. Because the antibody in the immunotoxin is unable to enter the cell, at times a large dose of radioactive material must be attached to the antibody for it to kill cancer cells. And because the doses required are so large, immunotoxins also harm healthy cells.

Studying IL-2's effectiveness

The clinical study at UH, headed by Chief of Medical Oncology Ronald P. McCaffrey, M.D., will involve 30 patients afflicted with cancers of the blood and lymph-forming system. According to McCaffrey, the criteria for patients entering the study are that "their condition has failed to respond to standard therapy, and their diseased cells have receptors for IL-2."

Although the IL-2 receptor was first thought to be found only on cells from adult T-cell leukemia

How IL-2 Toxin Works



The above illustration shows how IL-2 toxin enters an IL-2 receptor-positive cancer cell and kills the cell. The drawing at bottom left illustrates how immunotoxins—a parallel approach to cancer therapy—are unable to penetrate the cancer cell's structure.

(ATL), it now is known to be present on several kinds of leukemias and lymphomas. "We will focus primarily on chronic lymphocytic leukemia (CLL) in the beginning of the study, but also will involve appropriate ATL patients," McCaffrey says.

Chronic lymphocytic leukemia, the most common form of leukemia in the Western Hemisphere, is most often found in older patients, who range in age from 40 to 70. CLL, which sometimes doesn't present symptoms early on, develops when defective white blood cells replicate and decrease the production of protective antibodies, which makes the patient vulnerable to infection, and eventually may invade bone marrow and various organs. Traditional therapies for CLL include chemotherapy, steroids and radiotherapy; most patients survive for five to 10 years being

treated with these therapies.

Adult T-cell leukemia is a deadly disease with no current therapeutic intervention; in acute phases, many patients die within five months of diagnosis. Physicians concerned about the morbidity of the disease are equally concerned about the threat of transmission, since ATL is associated with the retrovirus HTLV-1 and has the same form of transmission as the AIDS virus. This type of leukemia is most prevalent in southern Japan, Africa, and the Caribbean, but also has been seen with increasing frequency in needle-sharing drug addicts in New York, New Orleans and Newark, New Jersey.

McCaffrey says that patients in the study will first be administered the drug and then will be observed for several weeks to measure its benefit. If the drug proves effective, the patients will continue on the therapy until

they reach "a maximally tolerated dose or maximally effective dose," he adds. "And although it is not part of the FDA-approved study, we also will be looking separately at whether a patient's cells are sensitive to the toxin in the laboratory."

"We're going to learn an awful lot from these clinical trials. In addition to levels of safety and tolerability, we will learn a great deal about the pharmacokinetics and pharmacodynamics of this molecule," says Murphy. "This will allow us to go back to the drawing board and further refine the drug. If you were to ask 'can we make it better?,' the answer will almost certainly be yes. I would be extremely surprised if this prototype of IL-2 toxin were the best agent." But because of the new-found ability of scientists like Murphy to genetically design drugs, IL-2 toxin should evolve into a clinically useful agent more quickly than traditional therapies.

A novel approach to research

"This hybrid protein is most certainly the start of this type of research; that is, research that sets out to design new therapies for specific purposes," says Murphy.

The IL-2 toxin is the result of innovative genetic engineering techniques performed by Murphy and his colleagues, particularly Terry Strom, M.D., director of Clinical Immunology at Beth Israel Hospital in Boston.

Murphy notes that approximately 800,000 agents have been tested as potential cancer therapies, and of that number, only about 40 agents are available on the market today. What is interesting about the IL-2 toxin is that while most cancer therapies are tested because of a promising, and often accidental, discovery in a laboratory, "the IL-2 toxin is the first drug to enter clinical trials that was specifically designed

and engineered to perform a particular task," he adds.

Most drugs go through several stages of investigation, in which derivatives of the original drug are developed and tested in pursuit of a final, refined commercial product. "The beauty of this study is that we knew from the beginning what diseases it would be tested for," says McCaffrey. "Most experimental cancer therapies are non-specific and need to be tested against nearly every form of cancer."

In addition to its potential

'IL-2 is the first drug tested in patients that was designed for a particular task'

benefit against leukemia and lymphoma, IL-2 toxin also has shown great promise in several other areas, especially in autoimmune disease. "There are a number of autoimmune diseases in which T-cells with IL-2 receptors play a major role," Murphy points out. "For example, in the case of diabetes, rheumatoid arthritis, multiple sclerosis and myasthenia gravis, it could be that IL-2 toxin, or perhaps a derivative of it, could play a therapeutic role."

Another area that could benefit from IL-2 toxin is acute graft rejection in patients with newly transplanted kidneys, hearts, livers and other organs. In

fact, before IL-2 receptors were found in certain cancer cells, Murphy and Strom were directing their research toward graft transplants.

But Murphy cautions that the more immediate application may be in the area of autoimmune disease. "That is not to say that the IL-2 toxin will not be helpful in graft transplantation, but acute graft rejection tends to have very dramatic T-cell mediated reactions, while autoimmune diseases have a smoldering reaction that may be more conducive to IL-2's therapeutic effect."

"The concept of [Dr.] Murphy's research, taking a cancer cell's nutrients—its growth factor—and linking it to a toxin, can be applied to a wide range of cancers and other diseases," McCaffrey points out. "For example, there is a growth factor in lung cancer, known as bombesin, that we think could be useful in directing a toxin to lung cancer cells. It is very exciting, rational research."

As a measure of the high quality of this biomolecular research, the National Cancer Institute (NCI) has awarded a research grant to establish a National Cooperative Drug Development Group, consisting of Murphy, Strom, McCaffrey, Vickie Kelley, Ph.D., of Brigham and Women's Hospital, and representatives from the NCI and Seragen, Inc. This group, one of nine drug development groups throughout the U.S., will further IL-2 toxin research with the hope of advancing its clinical introduction more quickly.

Bringing research to the bedside

With the recent opening of the Hospital's new biomolecular medicine laboratory, a state-of-the-art facility has been made available for advanced biomolecular research. Because most biomolecular laboratories are located in basic science

facilities or in research institutions, interaction among scientists, physicians and patients tends to be limited.

"This laboratory will allow for a more natural interaction between basic research scientists, physicians and patients," says Norman G. Levinsky, M.D., Director of the Evans Department of Medicine. "Formerly, scientists had little or no contact with patients or physicians."

"What is most significant about this laboratory, aside from its open design which allows for increased efficiency in conducting research, is that it is a reaffirmation by the Evans Medical Foundation and the Hospital of the importance of basic science as it applies to clinical medicine," says Murphy.

Michael R. Paskavitz

■ FOR YOUR INFORMATION

Dr. Murphy is the chief of the Section of Biomolecular Medicine at the University Hospital. He also is a professor of medicine at Boston University School of Medicine.



Dr. McCaffrey is chief of the Section of Medical Oncology at the University Hospital, and is a professor of medicine at the School of Medicine.



If you would like more information on the IL-2 toxin, or on medical oncology or biomolecular medicine services at the University Hospital, please call 1-800-842-3648.



FACING THE FACTS

UH Skin Oncology Program responds to a rise in the number of skin tumors and cancers

BY PAULA A. GILLIGAN

Even with a greater public awareness of the causes of skin cancer, approximately 400,000 new cases are diagnosed each year—an estimate that exceeds the combined number of all other cancers. Of further concern is the steady increase in cases of complex skin tumors, which has prompted physicians at the University Hospital to create a Skin Oncology Program.

"Clearly the incidence of skin cancer is on the rise and that is a concern," says Program co-director Gary S. Rogers, M.D. "But we also are seeing more patients who have complex tumors that need the expertise of several specialists. We don't exactly know why we're seeing more of these patients, but we believe this program will optimize their care."

The majority of skin tumors are of unknown origin, or they develop as a result of severe skin cancer, such as malignant melanoma. But other skin tumors have been associated with heredity, exposure to chemical agents like arsenic, and immunosuppression, as in the case of high-risk organ transplant patients. Approximately 90 to 95 percent of skin tumors appear on the face and neck.

Some skin cancers are superficial and spread mainly along the

skin surface, and they can be dealt with through topical medication or surgical removal of the tumor. But other tumors, such as invasive carcinomas, carry a threat of invading deeper tissues in the body, including the eyes, bone, the sinuses, and the mouth. Malignant melanoma carries a significant risk of spreading to internal organs. Treatment of skin cancer may require the involvement of several different medical specialties.

The UH Skin Oncology Program takes advantage of a key attribute of teaching hospitals, the ability to bring into play specialists in a multitude of disciplines. For example, a patient who has a cancerous tumor of the eyelid or invading the musculature of the eye would likely undergo Mohs surgery—a microscopically controlled method of surgery, highly effective in treating certain skin cancers—and then would undergo reconstruction by an oculoplastic surgeon, who would repair the functional and cosmetic damage to the eye.

The University Hospital is one of only 50 U.S. medical centers to have a Mohs surgery program, and UH is the only institution in the country to integrate Mohs surgery with an ambulatory surgical center.

The program's staff includes experts from several disciplines, so that the patient can receive

the full range of evaluation and treatment under one roof. The Skin Oncology Program is unique in that its multidisciplinary approach addresses all the needs that a patient afflicted with the disease may have.

How the program works

Heading the Skin Oncology Program are Howard Koh, M.D., F.A.C.P., and Rogers, of the Hospital's Department of Dermatology. As dermatologists, they already had been treating unusual and medically complex skin cancers, particularly malignant melanoma. Both have a special expertise in skin oncology,

studying quality of life and morbidity in facial cancer patients.

"About a year ago, we decided to formalize our activities and establish the Program, since our interests and expertise complemented each other," explains Koh. "Most of the patients that each of us saw had complex problems and required extensive care," says Rogers. "Our idea was to integrate the method of treatment so the patient could be treated in one place."

All patients are referred to the Skin Oncology Program by other physicians, most often their primary care physician. The patient's condition may have already been diagnosed by his or her physician, or it may need to be evaluated. Patients are treated on both an inpatient and outpatient basis, depending on the severity of illness.

If a skin cancer, such as basal cell carcinoma, is diagnosed, surgery is often recommended. Although this particular type of cancer usually is not fatal, it can invade and damage other tissues in the body. For example, if the original cancer site is found on the face, there is a chance the cancer may infiltrate and invade an underlying structure, such as the sinuses. In this case, Mohs surgery would be performed in concert with otolaryngology, and perhaps followed up by radiation medicine.

Koh and Rogers have assembled a team of more than 35 physicians at UH, who have agreed to offer their expertise in appropriate cases. Their areas include dermatology, epidemiology, laboratory medicine, medical and surgical oncology, ophthalmology, otolaryngology, pathology, plastic surgery, radiation medicine and social services.

Education and prevention

Preventive medicine, particularly for skin cancer, can be very effective

in decreasing the incidence of the disease. "The risk factors for skin cancer are well-known," explains Koh, "which is why education and prevention are so important." One of the goals of the program is to teach patients and patients' families ways to prevent the occurrence of the disease, especially for those types of skin cancers that may be hereditary. Educating the public on how to diminish the chance of getting skin cancer and what to look for in self-screening are other areas of emphasis.

With rising numbers of skin cancer and complex skin tumors in the U.S., Koh and Rogers believe the involvement of many specialists will be needed to offer skin tumor patients optimal results. "In the age of diverse specialization, this is a way to draw together all factions of physicians who treat the disease," says Rogers.

'We don't know why we're seeing more patients with complex skin tumors'

Koh holds a joint appointment in medicine, and Rogers in surgery. Koh heads the medical portion of the Program; he directs the photopheresis unit at UH for patients with cutaneous T-cell lymphoma/Sezary's syndrome—a severe form of skin cancer that migrates into the bloodstream, causing leukemia. Rogers runs the dermatologic surgery program, which specializes in Mohs surgery.

Both physicians are active in clinical skin cancer research. Rogers is involved in researching oncogene (cancer causing genes) activation in skin cancer, and is

■ FOR YOUR INFORMATION

Dr. Koh is a member of the staff of the University Hospital, and is an assistant professor of dermatology, medicine and public health at Boston University School of Medicine and School of Public Health.



Dr. Rogers is a member of the UH Department of Dermatology, and is an assistant professor of dermatology and surgery at the School of Medicine.



If you would like more information on the Skin Oncology Program, or on related services at the University Hospital, please call 1-800-842-3648.

NAMES



■ On June 12, 1989, the Boston University Medical Center community suffered a great loss in the passing of **Joseph Stokes III, M.D.**, a member of the Evans Department of

Medicine's Section of Epidemiology/Preventive Medicine and a co-principal investigator of the renowned Framingham Heart Study. Dr. Stokes, who recently had been honored by his colleagues with the prestigious Distinguished Service Award of the American College of Preventive Medicine, also was a professor of medicine and public health at Boston University School of Medicine and the School of Public Health, respectively.

In addition to his Medical Center appointments, Stokes was an adjunct professor in the Nutrition Program at Sargent College of Allied Health Professions; a research associate at the Center for Educational Development in Health at Boston University, and a lecturer in the Department of Preventive Medicine at Harvard Medical School.

The editor of the *American Journal of Preventive Medicine*, Stokes previously was an associate editor of the *New England Journal of Medicine* and also was the former dean of the medical school at University of California at San Diego.



■ **James S. Hoyte**, former Massachusetts Secretary of Environmental Affairs from 1983 through 1988, has been elected to the Hospital's Board of Trustees.

Hoyte, who currently works for the environmental law group of Choate, Hall & Stewart, is a graduate of the Kennedy School of Government of Harvard University, and also received his undergraduate and law degrees from Harvard. Prior to his state cabinet appointment, he was a vice president of a subsidiary company of Arthur D. Little, Inc., and also was secretary-treasurer of the Massachusetts Port Authority (Massport).

News & Names



■ **Richard A. Cohen, M.D.**, a member of the Hospital's Peripheral Vascular Section of the Department of Medicine, was elected president of the American Federation of Clinical

Research (AFCR), a prestigious national organization representing more than 12,000 clinical and basic research scientists. Cohen, who is on the editorial boards of the *American Journal of Physiology* and *Heart and Circulatory Physiology*, will serve as president-elect until he begins his term as president next year.



■ **Karen K. Kirby, R.N.**, senior vice president for Nursing at UH, was awarded the eighth annual Mary B. Conceison Award of the Massachusetts Organization of Nurse Executives (MONE) for outstanding contributions made as a nursing administrator. Kirby is MONE's immediate past president; she has been the Hospital's senior nursing executive since 1983.

Kirby is MONE's immediate past president; she has been the Hospital's senior nursing executive since 1983.



■ **Jerome H. Shapiro, M.D.**, chief of the Department of Radiology at UH and professor and chairman of the Department of Radiology at Boston University School of Medicine,

was recently named president-elect of the American College of Radiology (ACR), a prestigious national organization of radiologists. Shapiro, who has

received numerous distinctions in the field of diagnostic radiology, will assume the office of president of the ACR next year. A graduate of Yale University School of Medicine, Shapiro has been at Boston University School of Medicine since 1963.

NEWS

■ With a theme of "The Golden Days of Radio," the University Hospital's 12th Annual Gala Event proved a tremendous success as more than \$65,000 in net proceeds were raised to support UH's Annual Fund. The black-tie affair, held in the America Ballroom of the Westin Hotel at Copley Place, was attended by nearly 500 UH supporters and generated the largest amount of corporate sponsors ever.

Hosted by Ron Della Chiesa of WGBH's "MusicAmerica," the gala



Eight to the Bar provided the evening's dance music

fundraiser took guests on a journey back to the 1940s by recreating a live radio broadcast. Among the performers that evening were professional storyteller Jay O'Callahan, New York City cabaret singer Carol Abercrombie, and the Boston Arts Group, who performed a live version of the famous radio show, "The Shadow." Dance music was provided by the swing band Tuxedo and the show band Eight to the Bar.

■ At the Hospital's first conference on cultural diversity in the workplace, former New York Congresswoman Shirley Chisholm delivered a strong message that called

for sensitivity and willingness to change as key factors in creating a culturally diverse workplace. Chisholm, the first black woman elected to the United States Congress and the first black woman to run for the Presidency, was the keynote speaker at the full-day conference, which was held in the Hospital's Keefer auditorium. Using statistics and anecdotes, as well as candor and humor, Chisholm spoke strongly about her topic, "Unity and Diversity." She concluded her message by stating, "We must recognize that in America, we are all related. We are all fellow travelers on the same Earth trip." The University Hospital has been cited for leadership in creating a culturally diverse workplace.

IN THE NEWS

Since the last issue of *Progress*, the following University Hospital and/or Boston University School of Medicine health professionals have appeared in the media as expert sources for news stories:

Gaspar W. Anastasi, M.D., chief, Department of Plastic Surgery, was quoted in a *Good Housekeeping* article on removing scars and birthmarks.....**Anna Bissonnette, R.N.**, Home Medical Service, was the subject of a *Waltham News-Tribune* feature article about her work with the elderly community.....**Edith DeVegvar**, Social Services, was quoted in a *Boston Globe* article concerning a new program for caretakers of the elderly.....**Richard A. Cohen, M.D.**, Section of Peripheral Vascular Medicine, was quoted in an Associated Press (AP) story on vascular problems relating to Boston Red Sox pitcher Oil Can Boyd's arm injury.....**Richard H. Egdahl, M.D.**, director, Boston University Medical Center, was interviewed for a WBZ-TV Channel 4 news report on medical resident's hours in Massachusetts.....**R. Curtis Ellison, M.D.**, chief, Section of Preventive Medicine/Epidemiology, appeared in an Associated Press (AP) and *New Bedford Standard-Times* stories on low



Ellison

cholesterol diets for kids, and in the *Boston Globe* concerning his low-fat breakfast research.....**David P. Faxon, M.D.**, Section of Cardiology, appeared in a *Providence Sunday Journal*



Gilchrest

article on intra-arterial lasers as a possible therapy for atherosclerosis.....**Merrill I. Feldman, M.D.**, chief, Department of Radiation Medicine, was named as one of the country's top radiation oncologists by 200 medical school faculty members in a *Good Housekeeping* article on "The 184 Best Breast Cancer Doctors." He also appeared in a *New York Times* article and on WXLO-FM radio (San Francisco) concerning his involvement in a study on the benefits of chemotherapy in early-stage breast cancer.....**Edward Fischer, M.D.**, Department of Neurosurgery, was quoted in a *Boston Globe* article about the Boston Medflight emergency helicopter service.....**Thomas F. Freddo, O.D.**, Department of Ophthalmology, appeared in *Boston Herald* and *Boston Globe Magazine* articles on sunglasses.....**Barbara A. Gilchrest, M.D.**, chief, Department of Dermatology, was interviewed for a *Waterbury (CT) Republican* article on skin safety and the sun.....**Donald R. Giller**, vice president, Marketing/Planning/Public Affairs, was quoted in *Boston Herald* and *Boston Business Journal* articles on the fiscal plight of Massachusetts hospitals, and was quoted in an *American Medical News* article on trends in health-care marketing and advertising.....**Paul J. Hesketh, M.D.**, Section of Medical Oncology, was in *USA Today*, *Boston Herald* and *Boston Globe* articles on his work with a new antiemetic agent for chemotherapy patients.....**Michael Holick, Ph.D., M.D.**, head, Metabolic Bone Disease Clinic, was quoted in a *Health* magazine story about vitamin D treatment for psoriasis, and in a *Sunday Telegraph (Hudson, NH)* article on vitamin D and bone loss.....**Robert E. Leach, M.D.**, chief,



Moskowitz

Department of Orthopedic Surgery, was quoted in a *Boston Globe* article on the longevity of professional athletes, and was interviewed for *Boston Globe* and *Boston Herald* articles on his patient, marathoner Joan Benoit-Samuelson.....**Lawrence J. Markson, M.D.**, Division of Medicine, was interviewed by the *Boston Globe* and Channel 2 for stories on living wills.....**Mark A. Moskowitz, M.D.**, head, Section of Internal Medicine, appeared in *USA Today* and *Boston Globe* articles on physician roles in patient decision-making, and also was featured in a *Boston Herald* article on knowing when you're sick enough to stay home from work, and appeared as well in a *Daily Times-Chronicle (Woburn)* article on the

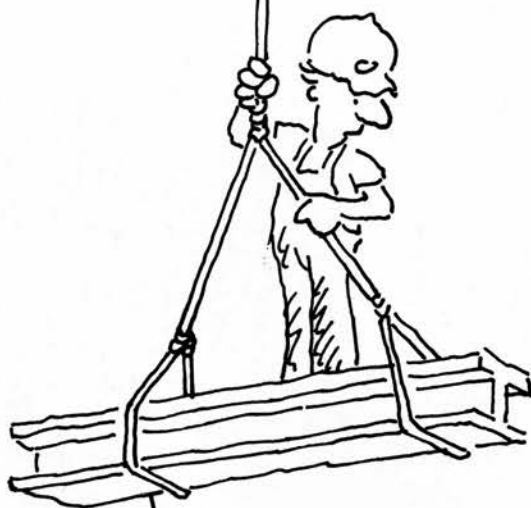


Ryan

need for more outpatient training among doctors.....**John R. Murphy, Ph.D.**, chief, Section of Biomolecular Medicine, was interviewed for *Patriot Ledger (Quincy)* and *Medical World News* articles on his IL-2 toxin's potential use in leukemia and lymphoma patients.....**Joseph Pietrafitta, M.D.**, Section of Surgical Oncology, appeared in a *Norwell Mariner* article on his research in treating esophageal cancer with lasers.....**Thomas J. Ryan, M.D.**, chief, Section of Cardiology, was interviewed for a *Washington Post* article on coronary angioplasty in post-heart attack victims, and he appeared in a *Boston Globe* story about heart care for different races.....**Inigo Saenz de Tejada, M.D.**, Department of Urology, appeared in *USA Today* and *Hartford Courant* stories on his research with impotency in diabetic men.....**Marie Saint-Hilaire, M.D.**, and **Linda Perry, R.N.**, Department of Neurology, appeared on a WODS-FM radio program, and were mentioned in *Boston Globe*, *Patriot Ledger (Quincy)* and *Boston Seniority* articles, about the Hospital's Parkinson's Disease Day Program.....**Oon T. Tan, M.D.**, Department of Dermatology, was featured in *Worcester Sunday Telegram* and *Haverhill Gazette* stories on treating portwine stains with lasers.

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There are an estimated 105 million workers in the United States. While most people associate occupational health hazards with "dangerous" jobs, like high-rise construction and hazardous waste clean-up, nearly every worker is likely to be exposed to some sort of work-related health or safety risk in their workplace. As the field of occupational health has evolved, employers have come to realize that the cost of keeping their employees healthy, safe and fit at work is the most sound investment they can make. By working with business and industry, the University Hospital's Occupational Health Program is doing its part, through patient care, medical education and research, to make "punching the clock" a healthy and safe experience.



See story page 8.